WITHIN CORPORATE LIMITS
NON-RESIDENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11209

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNSYLVANIA County: BEDFORD
City or town: HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: MRS. LUCRETIA ALBRIGHT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: MELVIN C. ALBRIGHT
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): MARCH 16 1906

8. AGE:

Years	Months	Days	If less than one day
34	8	9	...hrs. ...min.

9. Birthplace: PENNSYLVANIA (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: GEORGE M. MILLER
13. Birthplace: PENNSYLVANIA

MOTHER
14. Maiden name: EMMA HOLLER
15. Birthplace: PENNSYLVANIA

16. Informant: Melvin C. Albright
Address: Hyndman Pa.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 11/28/40. (month) (day) (year)
Cemetery or crematory: Hyndman Pa.
Location: Hyndman Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman Pa.

19. NOV 27 40 (Date rec'd by registrar) Joseph S. Franklin, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 25 1940 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1940 to Nov 25 1940 and that I last saw h... alive on Nov 25 1940

Immediate cause of death	DURATION
Stroke following injection of Iodine	
Due to: Neglected	
Due to: Corpulency & Intoxication	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Coronary Thrombosis Nov 20 - 40 Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Enfield M. D. or other
Address: Cumberland Date signed: 11/26/40

DR. ENFIELD

VS A15 (T) (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

11201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 906 Gay St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 906 Gay St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jesse Burnell Anderson

3. (b) Social Security Number None

4. Sex: male

5. Color or race: White

6.(a) ~~Single~~, married, ~~widowed, or divorced~~: married

6.(b) Name of ~~husband or~~ wife: Polly J. Twigg

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1865

8. AGE: Years 74 | Months 11 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Ursine Pa
(Town, county, and state)

10. Usual occupation: Conductor. Last worked 12 yrs.

11. Industry or business: B+O. R.R.

FATHER
12. Name: Geo Anderson
13. Birthplace: Pa.

MOTHER
14. Maiden name: Unknown.
15. Birthplace:

16. Informant: Harry Anderson
Address: 906 Gay St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22 1940 (month) (day) (year)

Cemetery or crematory: Davis memorial

Location: Cumberland, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md

19. 11-22 1940 (Date rec'd by registrar) Joseph P Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1940 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 1940 to Nov. 19 1940 and that I last saw him alive on Nov. 19 1940

Immediate cause of death: Cerebrovascular Hemorrhage — DURATION 10 yrs

Due to: Coronary Occlusion — 1/2 day

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. B. Owen M. D. or other

Address: 133 Va Ave Date signed: 11 20 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

11202

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 N. CENTRE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MISS. ANNA BALL

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1888

8. AGE: Years	Months	Days	If less than one day
52	8	18	..... hrs. ..... min.

9. Birthplace PENNSYLVANIA, Bedford County,
(Town, county, and state)

10. Usual occupation House Work

11. Industry or business —

FATHER
12. Name JOHN BALL
13. Birthplace Bedford County, Pa

MOTHER
14. Maiden name MARY Moran
15. Birthplace Unknown

16. Informant Scott Tewell
Address 423 N. Center St - Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland Md.

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. Nov. 5 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DRS. KOON & W.F. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 3, 1940 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1940 to 11-3-1940 and that I last saw her alive on 11-3-1940

Immediate cause of death	DURATION
Arteriosclerosis	?
C.L.v. Nephritis	
Due to (Uremia) Cerebral Hemorrhage	Since 10.27.40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 11-4-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

11203

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 43 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna County Bedford

City or town Artmes R. D. 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ambrose Barnes

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Aerie E. Barnes

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) March 25, 1864

8. AGE: Years 76 | Months 7 | Days 11 | If less than one day ___ hrs. ___ min.

9. Birthplace Mann Township Pa
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Barnes
13. Birthplace Pa

MOTHER
14. Maiden name Lizzie Jay
15. Birthplace Pa

16. Informant Virgil M. Barnes
Address 417 Holand St Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 19, 1940
(month) (day) (year)

Cemetery or crematory Pine Grove Cemetery

Location Everett R.D.

18. Funeral director D. S. Gump & Son
Address 24 W. Main St. Everett, Pa

19. Nov. 16 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16. 1940, at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1940, to Nov 16 1940, and that I last saw him alive on Nov 15 1940.

Immediate cause of death: Pulmonary Embolism

Due to: Mitr - Infarction

Due to

Other conditions: Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Cate of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 122 So Centre St Date signed 12880

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-d

11204

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Gilmore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs 4 mos. 27 days

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Gilmore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Elijah Morton Beaman

3. (b) Social Security Number: 215-05-9903

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Clarabelle Clise Beaman

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 4, 1881

8. AGE: Years 59 | Months 5 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace: Miller Mine - Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER
12. Name: Martin Beaman
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rachael Ross
15. Birthplace: Unknown

16. Informant: Mrs. Elijah Beaman
Address: Gilmore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. Nov. 4 1940 (Date rec'd by registrar) E. Oon Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1st 1940, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1940, to Nov 1st 1940 and that I last saw him alive on Oct 30th 1940

Immediate cause of death: Dilatation of heart due to valvular deficiency

Due to

Due to

Other conditions: Ascites

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Do Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry W. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed: Nov 3 '40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11205

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 325 Frederick st
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 325 Frederick st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Lawrence Brady

3. (b) Social Security Number 159-16-6480

4. Sex M | 5. Color or race C | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frances Brady
6(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 20, 1894

8. AGE: Years 46 | Months 4 | Days 28 | If less than one day ____ hrs. ____ min.

9. Birthplace Mansfield W Va
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business WPA

FATHER 12. Name Joseph Brady
13. Birthplace Mansfield W Va

MOTHER 14. Maiden name Annie Hillery
15. Birthplace Williamsport W Va

16. Informant Mrs Frances Brady
Address 326 Frederick st Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov 20/40
(month) (day) (year)
Cemetery or crematory Sunset Cemetery
Location Cumberland, Md

16. Funeral director William H. Kight
Address Cumberland Md

19. Nov. 21 1940 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1940, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1940, to Nov. 15 1940
and that I last saw him alive on Nov. 14 1940.

	DURATION
Immediate cause of death Coronary Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations no
Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE D. T. Langston, M. D. or other
Address 54 N. mech. st Date signed 11-19-40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (170-e)

11206

Ernest W. Broomall

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Rural, Near Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? Dead when admitted

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Philadelphia
City or town: Philadelphia, Germantown Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5436 E. Walnut Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ernest W. Broomall

3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary Elizabeth Rihl
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Dec. 3 - 1882

8. AGE: Years: 57 Months: 11 Days: 8 If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Civilian Worker Navy Yard
11. Industry or business: Supply Dept.
FATHER
12. Name: Horace T. Broomall
13. Birthplace: West Chester, Pa.
MOTHER
14. Maiden name: Mary Jane Wilson
15. Birthplace: Pa.
16. Informant: Mrs Mary Trumbauer
Address: 5733 Chew St. Germantown
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12 40 Pa (month) (day) (year)
Cemetery or crematory: Westminster Cem.
Location: Philadelphia Pa.
18. Funeral director: Jacob Hafer
Address: Frostburg, Md
19. Nov. 12 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11th., 1940 about at 12.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Dislocation at atlas-axis artculation, with fracture of axis. Fractured larynx. — DURATION: Instant death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Nov. 11th., 40
Where did injury occur? Near Frostburg, Allegany, Maryland. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto accident Injured at work? no

23. SIGNATURE: Lynne H. Boison M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 11/11/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 22 1940
BUREAU V. R.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-c

CERTIFICATE OF DEATH

Reg. Dist. No. 11207 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pa County: Philadelphia

City or town: Germantown Phila., Pa (If outside city or town limits, write RURAL and give nearest town)

Street No. 543 E. Walnut Lane (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Elizabeth Broomall

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Ernest W. Broomall

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.): Dec-6-1882

8. AGE: Years 57 Months 11 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Ribl

13. Birthplace: Pa

MOTHER 14. Maiden name: Gambling

15. Birthplace: Pa

16. Informant: Ribl Broomall

Address: 543 E. Walnut Lane

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 20 1940 (month) (day) (year)

Cemetery or crematory:

Location: Philadelphia, Pa.

18. Funeral director: Jacob Vater

Address: Frostburg, Md.

19. Nov. 18 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18th., 1940, at 9.30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Broncho-Pneumonia (unconscious since accident, November 11th., 1940 until death)	5 days
Due to	
Due to	
Other conditions: Fracture base of skull.	7 days

(Include pregnancy within 3 months of death)

Major findings of operations: Bloody spinal fluid. Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide or homicide~~: accident Date of 11/11/40

Where did injury occur? Near Frostburg, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto accident Injured at work? no

23. SIGNATURE: Lucie H. Corson, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 11/18/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 22 1940
BUREAU V. S.

Gattens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-e)

11208

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: WITHIN CORPORATE LIMITS

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred: Miner's Hospital, Frostburg

How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: Lysot Terrace (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Joseph Bruner

WITHIN CORPORATE LIMITS

3.(b) Social Security Number: 220-10-2281

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Vernon Bruner, Frostburg

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Oct 15, 1885

8. AGE: Years 55 | Months 1 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace: Vale Summit, Md. (Town, county, and state)

10. Usual occupation: W. P. A. Gobt.

11. Industry or business:

FATHER: 12. Name: John Bruner

13. Birthplace: Md.

MOTHER: 14. Maiden name: Marian Murray

15. Birthplace: Md.

16. Informant: John L. Bruner

Address: 21 Lee St, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1940 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

16. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. Nov. 17th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1940, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Nov. 15 1940 and that I last saw h. I.M. alive on Nov. 15 1940.

Immediate cause of death	DURATION
Cerebral apoplexy	3 days
Due to Central Nervous System Syphilis	3 months
Due to Syphilis	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: W. E. Gattens M. D. or other

Address: Frostburg, Md. Date signed: 11/16/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 3 1940
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-c)

11209

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Foundry Row
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Leslie Frederick Burall

3.(b) Social Security Number: 214-01-0166.

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Florence Uhl

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 6, 1904.

8. AGE: Years: 36 Months: 5 Days: 27 If less than one day: hrs. min.

9. Birthplace: Mt Savage, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Fire Brick Plant

FATHER
12. Name: George Wm. Burall
13. Birthplace: Wheeling, W. Va

MOTHER
14. Maiden name: Mary Rice
15. Birthplace: Harpers Ferry, Md.

16. Informant: Mrs Chas Burch
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5, 1940 (month) (day) (year)

Cemetery or crematory: Episcopal

Location: Mt. Savage

18. Funeral director: Jacob Hofer
Address: Frostburg, Md.

19. Nov. 3 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 1940, at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1940, to Nov. 2 1940 and that I last saw him alive on Nov. 2 1940.

Immediate cause of death: Acute Dilatation of Heart — DURATION: 1 day

Due to: Chronic Rheumatic Endocarditis. — 8 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. J. Bostetter M.D. M. D. or other

Address: Mt Savage Md Date signed: Nov 3-40

Dr Bostetter

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DEC 3 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-B

CERTIFICATE OF DEATH

11210

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hos
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: West Virginia County: Allegany
City or town: Newburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: West Virginia
(If rural give LOCATION)
2(o) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Hiram G Burke

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lucy Hamley
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 3 1867

8. AGE:

Years	Months	Days	If less than one day
73	10	5	hrs. min.

9. Birthplace: West Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Hiram G Burke
13. Birthplace: West Va.
MOTHER 14. Maiden name: Nancy A Riley
15. Birthplace: West Va
16. Informant: Mrs H G Burke
Address: Newburg, West Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 11 40 (month) (day) (year)
Cemetery or crematory: Newburg.
Location: West Virginia
18. Funeral director: Louis Steinman
Address: Cumberland Md
19. Nov 8 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1940, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-22-40 1940, to 11-8-40 1940, and that I last saw him alive on 11-8-40 1940.

Immediate cause of death: Carcinoma of prostate — DURATION: ?

Due to:

Due to:

Other conditions: Chronic nephritis with uremia. — DURATION: ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland Md — Date signed

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DEC 6 1940
BUREAU V. S.

11211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ✓

Stay in hospital or inst. (yrs., or mos., or days): ✓

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Alleg.

City or town: Midland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: James J. Canty

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ✓

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): July 23, 1883

8. AGE: Years 57 | Months 4 | Days 7 | If less than one day ___ hrs. ___ min.

9. Birthplace: Westernport, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Rubber Worker

11. Industry or business: Kelly-Tire Company

FATHER

12. Name: Michael Canty

13. Birthplace: Ireland

MOTHER

14. Maiden name: Catherine McPartland

15. Birthplace: England

16. Informant: William Canty

Address: Midland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1940 (month) (day) (year)

Cemetery or crematory: Belvedere Cemetery

Location: Midland, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec. 2 1940 (Date rec'd by registrar) E. Douglas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1940, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased~~ from ___ 19___, to ___ 19___, and that I last saw him alive on August 15 1940.

Immediate cause of death: Sudden death apparently due to Coronary Occlusion.

DURATION

Due to: Arteriosclerosis

Due to: (Certificate authorized by Dr. L. H. Corson, Coroner.)

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Cate of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R M Shelton Jr. M. D. or ~~other~~

Address: Midland, Md. Date signed 12-1-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11212

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Luigi Capriotti
'alias Louis Marini

3.(b) Social Security Number 217-09-1968

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1882

8. AGE:

Years	Months	Days	If less than one day
58	4	20	hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal miner

FATHER
12. Name Not known
13. Birthplace " " " "

MOTHER
14. Maiden name Not known
15. Birthplace " " " "

16. Informant Thomas White
Address Westernport, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 7, 1940.
(month) (day) (year)

Cemetery or crematory St. Peters cemetery
Location Westernport, Md.

18. Funeral director Ellsworth S. Boal
Address Westernport, Md.

19. Nov 7 1940 A J Paymbaker M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1940 at 11P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death acute myocardial failure

Due to Chr myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION
?

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Westernport Md Date signed 11-6-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

112139

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N. J. County Essex

City or town Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Wm Jennings Carney

3.(b) Social Security Number 210-01-3706

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Rhoda Griffith.

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 17, 1902

8. AGE: Years	Months	Days	If less than one day
38	5	24	..... hrs. ..... min.

9. Birthplace Frostburg Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Regional Director

11. Industry or business C.I.O. Union.

FATHER 12. Name Wm Carney

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Florence Parker

15. Birthplace Frostburg, Md.

16. Informant Jack Sparks

Address Box 304, Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14 1940 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg Md.

18. Funeral director Jacob J. Hafer

Address Frostburg, Md.

19. Nov. 13th 1940 (Date rec'd by registrar) Mrs. A. P. Walker Registrar

Dr. McCane.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1940 at 4.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11 1940 to Nov 11 1940

and that I last saw h.. alive on Nov 11 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden.
Due to epilepsy	7 Y.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm McCane Jr MD M. D. or other

Address Frostburg Md Date signed 11-12-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11214

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): about 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Cemetery Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Ellen Coglan

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Allen Coglan

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1873.

8. AGE: Years	Months	Days	If less than one day
67	10	7	hrs. min.

9. Birthplace: Hampshire, West Va., Mineral (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Joseph Martin

13. Birthplace: Scotland.

MOTHER

14. Maiden name: Catherine Johnson

15. Birthplace: Scotland

16. Informant: Miss Eleanor Coglan

Address: Westernport, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25, 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: W. H. Fredlock.

Address: Piedmont, West Va.

19. Nov. 25 1940 (Date rec'd by registrar) A J Bazinbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23 1940, to Nov. 23 1940, and that I last saw her alive on Nov. 23 1940.

	DURATION
Immediate cause of death: CORONARY Thrombosis	1 wk
Due to: Arteriosclerosis	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M. D. (M. D. or other)

Address: Piedmont W. Va. Date signed: 11/24/40

RECEIVED
DEC 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11215

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: —

Hospital, Institution, or street address where death occurred: 400 Race St.

How long in hospital or Institution?: —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 400 Race St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Ira Deneen

3. (b) Social Security Number: 705-07-6616

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruby Hinkle

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Jan 31 1870

8. AGE: Years	Months	Days	If less than one day
70	9	16	... hrs. ... min.

9. Birthplace: Fulton Co. Pa. (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: P.R.R. Co.

FATHER — 12. Name: Joab Deneen

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Mary Hogg

MOTHER — 15. Birthplace: Pa

16. Informant: Mrs. Ruby H Deneen

Address: Cumberland md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 20 1940 (month) (day) (year)

Cemetery or crematory: Warfordsburg Cem

Location: Warfordsburg Pa

18. Funeral director: Louis Stein Inc

Address: Cumberland md

19. Nov. 20 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17 1940 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 1940 to Nov. 17 1940 and that I last saw him alive on Nov. 17 1940

Immediate cause of death	DURATION
Chronic Myocarditis	1936
Due to Chronic Interstitial Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: M. G. Devers M. D. or other

Address: 133 Va Ave Date signed: 11/19/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
U. S.

11216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Barton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Barton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Shirley Jean Deniker

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: ✓

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1935

8. AGE: Years 5 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name John Deniker
13. Birthplace Meyersdale, Pa.

MOTHER
14. Maiden name Mary Mowbray
15. Birthplace Barton, Md.

16. Informant Mr. John Deniker
Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Fay Boal Berry
Address Westernport, Md.

19. Nov 19 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18th 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 1940, to Nov 18th 1940 and that I last saw her alive on Nov 8th 1940

Immediate cause of death Sarcoma of kidney

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other

Address Lonaconing, Md. Date signed Nov. 19th 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-a)

11217

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany.

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 126 Frederick St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lucy Caston

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Caston

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 7. 1863

8. AGE: Years 77 Months 5 Days 20 If less than one day ____ hrs. ____ min.

9. Birthplace: Buffalo Mills. Penna.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: George Bailey

13. Birthplace: Penna.

MOTHER

14. Maiden name: Lucy Sherman

15. Birthplace: Penna.

16. Informant: Mrs Clara Jones

Address: 618-12th St. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 8, 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland. Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland. Md.

19. Nov. 6 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1940, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1940, to Nov. 4 1940, and that I last saw her alive on Nov. 3 1940.

Immediate cause of death: Uremic Coma — DURATION: 1 day

Due to: Chronic Nephritis — 5 yrs

Due to: Arteriosclerosis — 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Chas. H. Kaan MD M. D. or other

Address: Cumberland Md Date signed 11/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 9 1940
BUREAU V. S.

Dr McLane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 112189

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 250 center (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Carrol Edwards

3.(b) Social Security Number: 220-03-7818

4. Sex: M

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Betty C. Edwards

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): July 20 — 1882

8. AGE: Years: 58 Months: 3 Days: 19 If less than one day: ..... hrs. ..... min.

9. Birthplace: Westminster - Carrol Md. (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Hotel

FATHER: 12. Name: Nelson Edwards

13. Birthplace: Westminster Md

MOTHER: 14. Maiden name: Frances Randel

15. Birthplace: Westminster, Md.

16. Informant: Mrs Betty C. Edwards

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-11-40 (month) (day) (year)

Cemetery or crematory: Ellsworth cemetery

Location: Westminster, Md

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. Nov. 10th 1940 (Date rec'd by registrar) Mrs. G. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1940, at 12 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden Death 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Dead when seen by me

Due to: Death evidently due to Coronary Thrombosis or Embolism

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: Sudden

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: Nov 9 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU V. M.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-01

11219

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany.

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 Dilley
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME George Conrad Ward Eichelberger

3. (b) Social Security Number 214-05-7716

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anna Gomer

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1908

8. AGE: Years 32 | Months 2 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Allegany Co, Md
(Town, county, and state)

10. Usual occupation: Taxi Cab Driver

11. Industry or business: Taxi Business

FATHER
12. Name: Warden Michael Eichelberger
13. Birthplace: Buffalo Mills, Pa.

MOTHER
14. Maiden name: Hattie Bruck
15. Birthplace: Glen Savage, Pa.

16. Informant: Mrs Geo. Eichelberger

Address: 529 Dilley St - Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 1, 1940. (month) (day) (year)

Cemetery or crematory: Trinity Lutheran

Location: Cumberland Md.

18. Funeral director: Jacob Hafer.

Address: Cumberland, Md.

19. Nov 30 19 40 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28 19 40, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/24/40 19 ..., to 11/28/40 19 ..., and that I last saw him alive on 11/24/40 19 ...

Immediate cause of death: Cerebral edema -

DURATION: -

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: John K. Rozum M.D. M. D. or other

Address: Cumberland Md Date signed 11/29/40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

11220

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Parkersburg Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Engle

3.(b) Social Security Number: 520-305-230

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Cecilia Engle

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 5, 1878

8. AGE: Years: 62 | Months: 4 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Eckhart-Alleg.-Md.
(Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business

FATHER
12. Name: Wm Engle
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Dudley
15. Birthplace: U.S.

16. Informant: Lester Engle
Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26-1940 (month) (day) (year)
Cemetery or crematory: Germans Lutheran Cemetery
Location: Frostburg, Md.

18. Funeral director: J. J. Hurst
Address: Frostburg, Md.

19. Nov. 24 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 21 1940 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 1940, to Nov 21 1940 and that I last saw h.. alive on Nov 21 1940

Immediate cause of death	DURATION
Chronic Myocarditis	??
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D McLane Jr MD
M. D. or other

Address: Frostburg Md Date signed: Nov 22 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 3 1940
BUREAU T. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13(a)

CERTIFICATE OF DEATH

11221

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: 916 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 916 Bedford St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Etta Fletcher

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William T Fletcher
6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Aug 5 1862

8. AGE: Years	Months	Days	If less than one day
78	3	23	...hrs. ...min.

9. Birthplace Buffalo Mills, Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER 12. Name Abraham Miller
13. Birthplace Pa.
MOTHER 14. Maiden name Anna M. Dicodemus
15. Birthplace Pa.
16. Informant Mrs Seth Oster
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30 40 (month) (day) (year)
Cemetery or crematory Fillcrest Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19. NV 30 19 40 (Date rec'd by registrar) Joseph P Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 19 40, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20th 1938, to Nov 28th 1940 and that I last saw h.. alive on Nov 28th 1940

Immediate cause of death	DURATION
Pneumonia	10 dys
(Cardiac Renal disease)	2 yrs
Due to Mitral Stenosis	
Due to General Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) None
Means of injury injured at work?

23. SIGNATURE J H Matthews M D
M. D. or other
Address 101 So Centre St Date signed 11/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-C

11222

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 8 hours 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town GREEN SPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Charles RAWLEY ~~FIRST~~ Dove

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15 1918

8. AGE: Years 22 | Months 5 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Romney, Hampshire, W. Va.
(Town, county, and state)

10. Usual occupation LABORER (IN ORCHARDS)

11. Industry or business

FATHER 12. Name George Dove (DECEASED)

13. Birthplace Romney W. Va.

MOTHER 14. Maiden name BESSIE ~~GREEN~~ SAVILLE

15. Birthplace Romney, ~~W. Va.~~ (DECEASED)

16. Informant Mrs Bessie Saville

Address Greenspring W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1940 (month) (day) (year)

Cemetery or crematory Forest Glen

Location Springfield

18. Funeral director Ireland & Griffin

Address Springfield Ohio

19. Nov 19 1940 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

DR. GROVE

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 17, 1940, at 9:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17. 1940 to Nov 17 1940

and that I last saw h.e.r. alive on Nov. 17. 1940.

	DURATION
Immediate cause of death Cerebral hemorrhage	11/17/40
Probable fracture skull	11/17/40
Due to automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11/17/40

Where did injury occur? (City or town) W. Va. (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Hit by automobile Injured at work?

23. SIGNATURE D. B. Grove, M.D.
M. D. or other

Address Medical Bldg Date signed 11/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

11223

Reg. Diat. No. 4

(M)

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs.
Hospital, institution, or street address where death occurred:
319 Cumberland Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 319 Cumberland Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eliza M. Frantz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm F Frantz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1853

8. AGE: Years	Months	Days	If less than one day
87	3	6	hrs. min.

8. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Jacob Wickard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Carleton
15. Birthplace: Maryland

16. Informant: Robert L. Frantz
Address: Cumberland, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 15, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland.

19. Nov. 15 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21st. 1940, to Nov 13 1940
and that I last saw her alive on Nov 12. 1940

Immediate cause of death	DURATION
Fracture of Rt hip.	7 days
Due to Accidental fall. Fell from back porch,	
at 119 Polk Street, Cumberland, Md.	
Due to Hypostatic Pneumonia	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Sept. 21st, 1940.
Where did injury occur? Cumberland (City or town) Allegany (County) Maryland (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: R C Brown M.D.
M. D. or other
Address: Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

11224

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Oak St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gaetana ~~Catherine~~ Franze

3.(b) Social Security Number None

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Domenico Franze

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 5 1897

8. AGE: Years 43 Months 9 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden name

15. Birthplace

16. Informant Domenico Franze

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 40 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Nov 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-40 19..... at 9.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1940 to November 7 1940 and that I last saw her alive on 11/7/40 19.....

Immediate cause of death Mesenteric Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Vaginal relaxation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K Rozner M.D. M. D. or other

Address Cumberland Md Date signed 11/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 14 1940
BUREAU V. R.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11225

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland R. 3

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: Allegany

City or town: Kempton Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Kempton Md. (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Opal Hazel Gaither

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Elmer G Gaither

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 4 1909

8. AGE:

Years	Months	Days	If less than one day
31	10	21	____ hrs. ____ min.

9. Birthplace: Kent Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Theodore Yazer

13. Birthplace: Pa

MOTHER

14. Maiden name: Sara Kaye

15. Birthplace: Penna.

16. Informant: Mrs Elmer G Gaither

Address: Kempton, West Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 25 40 (month) (day) (year)

Cemetery or crematory: Kempton Cemetery

Location: Kempton W. Virginia

18. Funeral director: Louis Stein Inc

Address: Cumberland. Md.

19. Nov. 23 1940 (Date rec'd by registrar) J. S. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 23 - 1940 at 3:35 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-11-1940 to 11-23-1940 and that I last saw h alive on 11-22-1940

Immediate cause of death	DURATION
Lobar Pneumonia	8 days
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: Wm J. Williams M. D. or other

Address: Cumberland. Date signed 11-23-40

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11226

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs

Hospital, institution, or street address where death occurred: 411 Furnace St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 411 Furnace St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Florence P. Gillard

3. (b) Social Security Number none

4. Sex: F.

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Late Louis P. Gillard

6.(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.): April 4, 1874

8. AGE: Years 66 | Months 4 | Days 4 | If less than one day ___ hrs. ___ min.

9. Birthplace: Belgium (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business: Housewife

FATHER
12. Name: August J. Paul Gillard
13. Birthplace: Belgium

MOTHER
14. Maiden name: Marie Reinord
15. Birthplace: Belgium

16. Informant: Hubert P. Gillard

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 11-40 (month) (day) (year)

Cemetery or crematory: St. Peter & Paul Cem.

Location: Cumberland, Md.

18. Funeral director: V. L. Lemperen

Address: Cumberland, Md

19. Nov 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1940, at 11:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1940, to Nov 8 1940 and that I last saw her alive on Nov 8 1940

Immediate cause of death: Cerebral Hemorrhage — DURATION: 6 hours

Due to: Chronic Nephritis — 3 yrs

Due to:

Other conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Kraus M. D. or other

Address: Cumberland Md Date signed 11/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83-a)

Reg. Dist. No. 8

11227

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Midland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 10 mos.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Alleg.
(c) City or town Midland (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertha Reynolds Gilpin

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband ~~or wife~~: Calvin Gilpin

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1876

8. AGE: Years 64 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Bloomington, Md. (Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER
12. Name George H. Barrick
13. Birthplace unknown

MOTHER
14. Maiden Name Mary Va. Reynolds.
15. Birthplace unknown

16 (a) Informant R. C. Sahee
(b) Address Thomas, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-40 (month) (day) (year)
(c) Cemetery or crematory Bloomington, Md.
Location Bloomington, Md.

18 (a) Funeral director C. W. Faulkner
(b) Address Piedmont, W. Va.

19 (a) Nov. 20-1940 (Date rec'd by registrar) (b) E. Oakley Registrar

MEDICAL CERTIFICATION

20. Date of death November 20 1940, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1940, to Nov. 20 1940, and that I last saw her alive on Nov. 19 1940.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. Shelton Jr. M. D. (M. D. or other)
Address Midland, Md. Date signed 11-20-40

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DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11228

83-a

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING
(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 DOUGLAS AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MR. EDWARD GREEN

3.(b) Social Security Number
21 [illegible] 9274

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ELIZABETH BEEMAN

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) JUNE 6 1874

8. AGE: Years	Months	Days	If less than one day
66	5	16	...hrs. ...min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation CARPENTER

11. Industry or business

FATHER
12. Name JEFFERSON GREEN
13. Birthplace MARYLAND

MOTHER
14. Maiden name Elizabeth Metz
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24 1940 (month) (day) (year)

Cemetery or crematory Crawford Mem.

Location Lonaconing, Md.

18. Funeral director Ellsworth S. Boal

Address Westernport Md.

19. Nov 22 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

DR. TOLSON & DR. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 22, 1940 at 11:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV 16 1940, to NOV 22, 1940 and that I last saw him alive on NOV 22, 1940

Immediate cause of death	DURATION
Arteriosclerosis with Cerebral hemorrhage	
Due to Hemiplegia.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D.
M. D. or other

Address Cumberland, Md. Date signed 11-22-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11229

Reg. Dist. No. 7

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Barton, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Louise Bell Beeman
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 1, 1867
8. AGE: Years 73 Months 10 Days 21 If less than one day hrs. min.
9. Birthplace Lonaconing, Alleg. Md. (Town, county, and state)
10. Usual occupation Coal Operator
11. Industry or business Coal Mine
FATHER 12. Name William Green
13. Birthplace Lonaconing, Md.
MOTHER 14. Maiden name Catherine Wilkes
15. Birthplace Lonaconing, Md.
16. Informant Mrs. Hugh Young
Address Barton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25 1940 (month) (day) (year)
Cemetery or crematory Shilos Cem.
Location Westernport, Md.
18. Funeral director Jay Coal Petry
Address Westernport, Md.
19. Nov 23 1940 S. A. Bowden
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1940 at 7:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1940 to Nov 22 1940
and that I last saw h. alive on Nov 2 2 1940

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions Broncholitis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other
Address Lonaconing, Md. Date signed Nov. 28 40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-E)

CERTIFICATE OF DEATH

11230

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred: Route #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone (If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1 (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Caroline McDonald Yarman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Abraham Yarman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 5.

8. AGE: Years	Months	Days	If less than one day
85	7	13	..... hrs. ..... min.

9. Birthplace: Yarman W Va (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: at Home

FATHER — 12. Name: Anthony McDonald.

FATHER — 13. Birthplace: Not known.

MOTHER — 14. Maiden name: —— Stonebraker

MOTHER — 15. Birthplace: Not Known.

16. Informant: Mrs. Ruth D. Heise

Address: Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20 1940 (month) (day) (year)

Cemetery or crematory: Burg Cem.

Location: Flintstone Route #1

18. Funeral director: Jacob Lafes

Address: Cumberland, Md.

19. Nov 20 1940 (Date rec'd by registrar) D Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1940 at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938 to November 1940 and that I last saw her alive on Nov 1 - 1940 19....

Immediate cause of death	DURATION
Progressive Anemia.	
Due to Old Age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: A. P. Twigg M. D. or other

Address: Flintstone Date signed 11-19-40

Dr Twigg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 3 1940
BUREAU F. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

11231

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 325 Cumberland St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Cumberland St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Findley C Hendrickson

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Edith Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22 1863

8. AGE: Years 77 Months 1 Days 1 If less than one day ..... hrs. ..... min.

9. Birthplace: Hazen, Md. (Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business: Self

FATHER 12. Name: Oliver P Hendrickson

13. Birthplace: Md

MOTHER 14. Maiden name: Sally A Folk

15. Birthplace: Md

16. Informant: Herbert Platt

Address: Cumberland Md

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Nov. 26 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Nov. 26, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-23-1940, at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-21-1940, to 11-23-1940 and that I last saw him alive on 11-23-1940

Immediate cause of death: Auricular Fibrillation

Chronic Endocarditis

Due to: Chronic Myocarditis

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed: 11-25-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11232

Reg. Dist. No.

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: MINERAL
City or town: PIEDMONT
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DONALD HENRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGER

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1927

8. AGE: Years	Months	Days	If less than one day
13	4	25	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: STUDENT
11. Industry or business

FATHER
12. Name: ARTHUR HENRY
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: ROSALIE RILEY
15. Birthplace: WEST VIRGINIA

16. Informant: Arthur Henry
Address: Piedmont W.Va

17. Burial, cremation, or removal. Which? Burial Date thereof: Dec 2, 1940 (month) (day) (year)
Cemetery or crematory: Thayer Cemetery
Location: Westernport Md

18. Funeral director: Ellsworth S. Boal
Address: Westernport Md

19. Rec'd 40 (Date rec'd by registrar) Joseph F. Franklin Registrar

DR. W.F. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 30, 1940 at 8:12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13 - 1940 to 11-30-1940 and that I last saw him alive on 11-30-1940

Immediate cause of death	DURATION
Ruptured Spleen	2
Due to	A
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Splenectomy Date of op. 11-30-40
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other
Address: Cumberland Date signed: 12-1-40.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

11233

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 874 Sperry Terrace
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 874 Sperry Terrace
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Laura V. Henry

3. (b) Social Security Number: None

4. Sex: F.
5. Color or race: W.
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Late Patrick C.
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): July 7-1866
8. AGE: Years: 74 Months: 4 Days: 16 If less than one day: ____ hrs. ____ min.
9. Birthplace: West Va (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: Patrick Cronn
13. Birthplace: Md.
MOTHER 14. Maiden name: Ellen Cronn
15. Birthplace: West Va
16. Informant: Mrs George Johnson
Address: Cumberland, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof Nov 26-40 (month) (day) (year)
Cemetery or crematory: Berkley Springs, W Va.
Location: Berkley Springs W Va.
18. Funeral director: V. L. Funkhouser
Address: Cumberland, Md.
19. (Date rec'd by registrar) Nov 26 19 40 Registrar: J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-23-40 19 6 40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-22-40 19 to 11-23-40 19, and that I last saw h[er] alive on 11-23-40 19

	DURATION
Immediate cause of death: Arteri-sclerosis	
Chronic myocarditis	
Due to (b) Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: W. Alfred Von Ohmen M. D. or other
Address: Cumberland, Md. Date signed 11-25-40

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11234

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: La Vale, Md. Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. La Vale Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ARTHUR HOLZSHU

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1892

8. AGE: Years 48 | Months 3 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Henry Holzshu
13. Birthplace Md

MOTHER 14. Maiden name Mary Reuschlein
15. Birthplace Md.

16. Informant Miss Marie Holzshu
Address LaVale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4. 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetary
Location Cumberland Md

18. Funeral director Louis Stein Sons
Address Cumberland, Md.

19. Nov 4 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1940, at 8:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1940, to Nov 1 1940
and that I last saw h. alive on Nov 1 1940

Immediate cause of death	DURATION
Streptococcic Septicaemia	1 week
Due to Haemangioma	4 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. Madeon M.D.
M. D. or other
Address Cumberland Md. Date signed 11-4-40

DR. F. WILSON

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

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DEC 6 1940
U. S.

Dr McLane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 11235

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: W. Mechanic (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Louise Hott

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: David W. Hott

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 25 – 1854

8. AGE: Years: 86 Months: 4 Days: 10 If less than one day: hrs. min.

9. Birthplace: Lonaconing-Alleg-Md. (Town, county, and state)

10. Usual occupation: invalid

11. Industry or business

FATHER: 12. Name: Wm Henry Miller

13. Birthplace: Germany

MOTHER: 14. Maiden name: Katherine Duckworth

15. Birthplace

18. Informant: Archie Hott

Address: Carlos, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-7-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. Nov. 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1940, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1940, to Nov 4 1940 and that I last saw her alive on Nov 4 1940

Immediate cause of death: Chronic Myocarditis — DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm McLane Jr MD M. D. or other

Address: Frostburg Md Date signed: Nov 6 1940

VS A15 (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1948
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

CERTIFICATE OF DEATH

11236

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 23 Va Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME HUFF

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-40

8. AGE: ~~Years~~	Months	Days	If less than one day
4 months in utero			hrs. min.

9. Birthplace Allegany Co Cumberland Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Carl Vernon Huff

13. Birthplace Ridgely W. Va

MOTHER 14. Maiden name Aldlint Virginia Pharas

15. Birthplace Elkins W. Va

16. Informant Mrs Carl V. Huff

Address 23 Virginia Ave

17. Cremated (Burial, cremation, or removal. Which?) Date thereof 11 29 40 (month) (day) (year)

Cemetery or crematory Allegany Hospital

Location Cumberland Md

18. Funeral director

Address

19. Nov 29 1940 (Date rec'd by registrar) Joseph Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1940, to Nov 28 1940, and that I last saw h alive on Nov 28 1940.

	DURATION
Immediate cause of death Miscarriage	immediate
Due to Cough on account of Bronchitis	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations	
Of autopsy	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 125 Bedford St Date signed 11-29-40

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

(M) (S)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

11237

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 23 Va. Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/40

8. AGE: Years | Months 4 months 28 days | Days | If less than one day hrs. min.

9. Birthplace Cumberland Md. Allegany Co.

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Carl Vernon Huff

13. Birthplace Ridgely W. Va

MOTHER 14. Maiden name Atkins Virginia Pharis

15. Birthplace Elkins W. Va

16. Informant Mrs. Carl V. Huff

Address 23 Va. Ave.

17. Cremated (Burial, cremation, or removal. Which?) Date thereof 11-29-40 (month) (day) (year)

Cemetery or crematory Allegany Hospital

Location Cumberland. Md

18. Funeral director

Address

19. Nov 29 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1940, at 2:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 1940, to Nov. 28 1940, and that I last saw him ~~in~~ alive on November 28 1940.

Immediate cause of death	DURATION
Miscarriage	Immediate
Due to cough on account of Bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D.

M. D. or other

Address 125 Bedford St. Date signed 11/29/40

RECEIVED
DEC 6 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

11238

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 14 Hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 201 Arch St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Walter Jackson

3.(b) Social Security Number
715-18-8751

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Ely
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): January 21, 1874

8. AGE: Years	Months	Days	If less than one day
66	10	3	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Railroad Brakeman
11. Industry or business: R. R. Co.
FATHER 12. Name: Henry Jackson
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Not Known
MOTHER 15. Birthplace: West. Va.
16. Informant: MARGARET JACKSON
Address: 201 Arch St., Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 27-40 (month) (day) (year)
Cemetery or crematory: Ebenezer Cem
Location: Romney, W. Va.
18. Funeral director: U. L. Leatherman
Address: Cumberland, Md.
19. Nov 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24, 1940 at 3:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20, 1940 to Nov. 24, 1940 and that I last saw him alive on Nov. 23, 1940

Immediate cause of death	DURATION
Chronic Myocarditis	1 Yr
Coronary Thrombosis	4 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clay E. Durrett, M. D. or other
Address: Cumberland Date signed: Nov 24, 1940

DR. DURRETT

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Strand Theatre
2780

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

11239

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany.
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 16 Altamont Terr.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany.
City or town: Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 16 Altamont Terrace.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Esther Jarvis.

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~: David H. Jarvis
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb 22 1896
8. AGE: Years 44 Months 7 Days 21 If less than one day ____ hrs. ____ min.
9. Birthplace: Brunswick Maryland. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER
12. Name: Joshua Humphrey
13. Birthplace: Springfield W. Va.
MOTHER
14. Maiden name: Carrie Manual
15. Birthplace: Harper's Ferry W. Va.
16. Informant: David H. Jarvis
Address: 16 Altamont Terr. City.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1940 (month) (day) (year)
Cemetery ~~or crematory~~: Hill Crest. Cemetery.
Location: Allegany Co. Md.
18. Funeral director: V. L. Tempereur
Address: 202 Green St. Cumb'd Md.
19. Nov. 14 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November - 13 1940, at 9:30 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1939 19__, to November 13 1940, and that I last saw her alive on November 13 1940.

Immediate cause of death	DURATION
Chronic Interstitial Nephritis	1938
Chronic Myocarditis.	1938
Due to arteriosclerosis.	1935
Due to	
Other conditions: Diabetes Mellitus	1930

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: H. W. Gleason MD M. D. or other
Address: 126 Union St. Cumberland Md Date signed 11/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU T. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95a)

11240

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution 692. Gephart Drive
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 73 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 692. Gephart Drive
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Janette Jordan

3. (b) Social Security Number

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Charles Jordan
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 19, 1852
8. AGE: Years 88 Months 7 Days 7 If less than one day hrs. min.
9. Birthplace West Liberty WVa (Town, county, and state)
10. Usual occupation House wife
11. Industry or business Own House
FATHER 12. Name Harold Sheppard
13. Birthplace West Liberty WVa
MOTHER 14. Maiden name Leula Grove
15. Birthplace West Liberty WVa
16. Informant Mrs W. H. Hughes
Address 692 Gephart Drive City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 28/40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland Md
18. Funeral director William H. Kight
Address Cumberland Md
19. Nov 27 1940 (Date rec'd by registrar) Joseph P. Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14, 1940 to Nov. 26, 1940, and that I last saw her alive on Nov. 26, 1940.

Immediate cause of death	DURATION
Auricular fibrillation	1 week
Due to	
Due to	
Other conditions Pulmonary edema	3 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Zimmerman M.D. M. D. or other
Address 1055 Centre St. Cumberland, Md. Date signed 11-27-40

VS A15 1454 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11278

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address (Hospital, or Institution): Sylvan Retreat
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 8 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Sylvan Retreat
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Margaret Appel Reiffer (Keiffer)

3. (b) Social Security Number none

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Geo Reiffer
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug 19 1859

8. AGE: Years 81 | Months 2 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Henry Appel
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Reisenweber
15. Birthplace: Germany

16. Informant: Mrs Sophia Rehring
Address: Littlestown, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14 '40 (month) (day) (year)
Cemetery or crematory St. Peters Cem.
Location Cumberland Md.

18. Funeral director: Louis Stein Sons
Address: Cumberland

19. Nov 14 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 — 11 — 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-5-1940 to 11-11-1940 and that I last saw h alive on 11-9-1940

Immediate cause of death	DURATION
Arteriosclerosis	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.
Of autopsy None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Wm F. Williams M. D. or other
Address Cumberland Date signed 11-12-40

VS A15

RECEIVED
NOV 18 1940
READY

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 146-C

11241

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 268 E. Main (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Genevieve Cecilia Kelly

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: John Kelly

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Sept 10 — 1911

8. AGE: Years 29 | Months 2 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace: Frostburg-Alleg-Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Frank Flannigan
13. Birthplace: Vale Summit, Md.

MOTHER
14. Maiden name: Catharine Carney
15. Birthplace: Frostburg, Md.

16. Informant: Miss Lauradine Flannigan

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12-1940 (month) (day) (year)

Cemetery or crematory: St Michaels

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Nov. 12th 1940 (Date rec'd by registrar) Mrs A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 1940, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 9 1940, to Nov 10 1940 and that I last saw her alive on Nov 10 1940

Immediate cause of death	DURATION
Uterine Hemorrhage	1/2 hr
Due to Retained Placenta	1/2 hr
Due to Pregnancy	Term
Other conditions Shock	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W O McLane Jr MD M.D. or other

Address: Frostburg Md Date signed: Nov 11 1940

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU Y. B.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

11242

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: MT. LAKE PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. LAURA KILLIUS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: LEWIS KILLIUS

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV. 19, 1877

8. AGE: Years	Months	Days	If less than one day
62	11	23	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: SAMUEL KLABAUGH
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: CHRISTINA DURST
15. Birthplace: MARYLAND

18. Informant: LAURA KILLIUS
Address: MT. LAKE PARK, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1940 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Oakland, Md.
18. Funeral director: Emory D. Bolden
Address: Oakland, Md.

19. Nov 4 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. GRACIE

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 2, 1940 12;55 AM ..... 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1940 to Nov 2 1940
and that I last saw h[illegible] alive on Nov 1 1940

Immediate cause of death	DURATION
Chronic Nephritis	
Due to Stones in Common Duct	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Stones in Common Duct
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. G. Green M.D. M. D. or other
Address: Cumberland Date signed: Nov. 2-4

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11243

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 217 Cecilia St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Frieda King.

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: James King

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Mar. 27. 1886

8. AGE: Years: 54 Months: 7 Days: 12 If less than one day: hrs. min.

9. Birthplace: Lonaconing Allegany Md. (Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business: Own Home

FATHER
12. Name: Joseph Baumann
13. Birthplace: Germany

MOTHER
14. Maiden name: Amelia Kimpfle
15. Birthplace: Pittsburg, Pa.

18. Informant: James King

Address: 217 Cecilia - Cumberland, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Nov. 12, 1940 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Nov. 9 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1940, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1940, to Nov 9 1940 and that I last saw her alive on Nov 9 1940

Immediate cause of death	DURATION
Uremia	1 wk.
Chr. parenchymatous nephritis	?
~~Due to~~ Chr. myocarditis	?
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Lyle R. Everhart M.D. M. D. or other

Address: 36 Greene St Cumberland Md Date signed: 11/9-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU T. B.

WITHIN CORPORATE LIMITS.

11244

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs!

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Polk Street
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME MRS. SUSAN A. KING

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Clarence M. King

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 26 1858

8. AGE: Years	Months	Days	If less than one day
82	2	15	hrs. min.

9. Birthplace Wellersburg Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER
12. Name James A Johnston
13. Birthplace Pa.

MOTHER
14. Maiden name Harriett Shaffer
15. Birthplace Pa.

16. Informant Mrs Emma Atkins
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14 '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.,
Address Cumberland.

19. Nov 14 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1940 at 7:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-7-1940, to 11-11-1940 and that I last saw her alive on 11-11-1940

Immediate cause of death: Broncho Pneumonia Generalized — DURATION 2 days.

Due to Arteriosclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 11-11-40

Dr. W.F. Williams

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

11245

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 83 W. Loo (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Conrad Anthony Lapp

3.(b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb 28 — 1862

8. AGE: Years: 73 Months: 8 Days: 26 If less than one day ... hrs. ... min.

9. Birthplace: Frostburg - alleg - md (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER: 12. Name: Conrad Lapp

13. Birthplace: Germany

MOTHER: 14. Maiden name: Catherine Krapf

15. Birthplace: Germany

16. Informant: Mrs Catheleen Todd

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26-1940 (month) (day) (year)

Cemetery or crematory: allegany

Location: Frostburg, Md.

18. Funeral director: J J Durst

Address: Frostburg

19. Nov. 26 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1940, at 12:00 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1940 to Nov 23 1940 and that I last saw him alive on Nov 23 1940

Immediate cause of death: Chronic Myocarditis — DURATION: ?

Due to: Chronic Nephritis

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W O McCane Jr M D (M. D. or other)

Address: Frostburg — Date signed: Nov 20 1940

RECEIVED
DEC 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17-2

CERTIFICATE OF DEATH

11246

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 18 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Russell Phillip Lashbaugh

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1923

8. AGE: Years	Months	Days	If less than one day
17	5	27	hrs. ..... min.

9. Birthplace: Borden, Md. - Allegany County
(Town, county, and state)
10. Usual occupation: None - at Home
11. Industry or business

FATHER
12. Name: Harmon Lashbaugh
13. Birthplace: Barton, Maryland

MOTHER
14. Maiden name: Julia Anne Porter
15. Birthplace: Eckhart, Md.

16. Informant: Wilbur E. Lashbaugh
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18, 1940 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage, Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. Nov. 17th 1940 (Date rec'd by registrar) mno. A. P. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15th., 1940 at 8.50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Probably pulmonary embolus. Comp. fracture right femur,	
lower third, comp. fracture right	
Due to: tibia and fibula, lower third.	
Due to:	
Other conditions: Hemorrhage, shock.	18 hours

(Include pregnency within 3 months of death)

Major findings of operation: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide or homicide: homicide Date of 11-14-40
Where did injury occur? Near Zihlman, Allegany, Maryland.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto accident Injured at work? no

23. SIGNATURE: Russell H. Larson, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 11/16/40

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-D

11247

CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Corriganville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Bertha E. Lepley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Lepley 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 15 1878

8. AGE:

Years	Months	Days	If less than one day
62	8	14	hrs. min.

9. Birthplace Keyser, W.Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry Crawford
13. Birthplace Md.

MOTHER
14. Maiden name Louise(Miller)Lepley
15. Birthplace Md.

16. Informant Robert Lepley
Address Corriganville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1940 (month) (day) (year)

Cemetery or crematory Wellersburg

Location Wellersburg, Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman Pa

19. Dec 1st 1940 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1940, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Nov 29 1940, and that I last saw h- alive on Nov 29 1940.

	DURATION
Immediate Cause of death Generalized Arterio-Sclerotic Heart Disease	1830.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D. M. D. or other

Address Hyndman Pa Date signed 11/29/40

RECEIVED
DEC 6 1940
BUREAU U. S.

VS A15 (M) (I) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 11248 6

1. PLACE OF DEATH:

County Allegheny

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va County Tucker

City or town Parsons,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Burl Clarence Lewis

3. (b) Social Security Number 233-20-1866

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1920

8. AGE:

Years	Months	Days	If less than one day
20	1	14	hrs. min.

9. Birthplace Parsons, West Va. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Nick Lewis

13. Birthplace West Va.

MOTHER

14. Maiden name Iva Simmons

15. Birthplace Tucker county, West Va.

16. Informant Nick Lewis, Cemetery

Address parsons, West Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20, 1940 (month) (day) (year)

Cemetery or crematory Parsons, Cemetery

Location Parsons, West Va.

18. Funeral director J. W. Minear

Address Parsons, West Va.

19. Nov. 20 1940 (Date rec'd by registrar) A. J. Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17th., 1940, at 5.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19

and that I last saw h alive on 19

Immediate cause of death Hemorrhage, Shock. (Deep, gaping wound, left axillary region, puncturing left lung, severing vessels of axilla; compound, communited fracture of third, fourth and fifth ribs.)

DURATION 15 minutes

Due to

Due to Compound fracture right tibia and fibula, middle third.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ accident Date of 11/17/40

Where did injury occur? Near Luke, Allegany, Maryland. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury automobile striking highway fence. Injured at work? no

23. SIGNATURE Prince H. Bowen, M.D. M. D. or other

Address Cumberland, Maryland. Date signed 11/18/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
DEC 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11249

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 413 Arch St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 413 Arch St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marie Antoinette Licot

3.(b) Social Security Number: none.

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband ~~or wife~~: Arthur Licot

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 3, 1870

8. AGE: Years 69 | Months 11 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace: Belgium (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Victor Dion
13. Birthplace: Belgium

MOTHER
14. Maiden name: Philomena Paul
15. Birthplace: Belgium

16. Informant: Miss Stella Licot

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11, 22-40 (month) (day) (year)

Cemetery or crematory: St. Patricks

Location: Cumberland Md

18. Funeral director: Virgil L. Lemperer

Address: 207 Green St Cumberland Md

19. 11-22 1940 (Date rec'd by registrar) Joseph P. Franklin MR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20, 1940, at 5:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20. 1940, to Nov. 20 1940 and that I last saw her alive on Nov. 22, 1940

Immediate cause of death: Coronary Thrombosis

Due to: Chronic Myocarditis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION: 1938

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Clay E. Lowers M. D. or other

Address: Cumberland Date signed: Nov 22, 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11250

(107)

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 4 weeks 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #2
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3. (a) FULL NAME Edward Oliver Lilles

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Child

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 21, 1939

8. AGE: Years 0 | Months 11 | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Melvin Lilles
13. Birthplace Cross Keys

MOTHER 14. Maiden name Florence Wilson
15. Birthplace Cumberland Md

16. Informant Melvin Lilles
Address Cumberland Rout #2

17. Burial Date thereof Nov 16 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pleasant Grove
Location Cumberland Balto Pike

18. Funeral director Jacob Yates
Address Cumberland Md

19. Nov. 16 1940 J. P. Franklin M.D. Registrar
(Date rec'd by registrar)

Dr Hodges

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1940 to Nov. 14 1940 and that I last saw h. alive on Nov. 14 1940

Immediate cause of death	DURATION
Meningitis	1 week
Due to Bronchio-pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W Royce Hodges M.D.
M. D. or other
Address Cumberland, Md Date signed 11-15-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
DEC 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

11251

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: R.F.D. #5 Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, Institution, or street address where death occurred: Bedford Rd., Route #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: R.F.D. #3 Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bedford Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Regina Catherine Lippold

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Joseph H. Lippold
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 18 1856

8. AGE: Years	Months	Days	If less than one day
83	11	14	hrs. min.

9. Birthplace: Bryant, Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: Gideon Albright
13. Birthplace: Garret Co. Pa.
MOTHER 14. Maiden name: Not Known
15. Birthplace: Not Known
16. Informant: Mrs. W. J. Hankins
Address: 134 Polk St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5 1940 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul's Cemetery
Location: Cumberland
18. Funeral director: Jack Hofer
Address: 230 Baltimore Ave. Cumberland
19. Nov. 5 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 19 40 at 3:20 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 19 40 to Nov 2 19 40 and that I last saw h[illegible] alive on Oct 31 19 40

Immediate cause of death	DURATION
Chronic Myocarditis	3 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. T. Trevaskis M.D., M. D. or other
Address: Cumberland, Md. Date signed: Nov 4-'40

-Trevaskis-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11252

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: 162 N. Center St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 162 N. Center St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ira Kemp Little

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beatrice S. Stiner
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Aug 19 1881

8. AGE: Years	Months	Days	If less than one day
59	2	26	...hrs. ...min.

9. Birthplace: Williamsport Md.
(Town, county, and state)
10. Usual occupation: Optometrist
11. Industry or business:
FATHER 12. Name: Jesse Little
13. Birthplace: Md.
MOTHER 14. Maiden name: Gertrude Batt
15. Birthplace: Md.
16. Informant: Beatrice S. Little
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 17 40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. Nov 17 1940 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1940, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1938, to Nov 15 1940 and that I last saw h.i.m. alive on Oct. 8 1940

Immediate cause of death	DURATION
Angina Pectoris	Acute
Due to: Chronic myocarditis	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D.
M. D. or other
Address: 46 N. Liberty St. Date signed 11-16-40

RECEIVED
DEC 6 1940
BUREAU V. S.

11253

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 8

1 PLACE OF DEATH

County Allegany

Village or City Midland Md. (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marble

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	white	—

6 DATE OF BIRTH: November 19, 1940 (Month) (Day) (Year)

7 AGE: ____ yrs. ____ mos. ____ ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry business, or establishment in which employed or (employer) ____

9 BIRTHPLACE (State or country) Allegany Co. Maryland

PARENTS

10 NAME OF FATHER George Marble

11 BIRTHPLACE OF FATHER (State or country) Perry Pa.

12 MAIDEN NAME OF MOTHER Mabel Juanita Thrasher

13 BIRTHPLACE OF MOTHER (State or Country) Midland Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Marble

(Address) Midland Md.

15 Filed Nov. 19 1940 E. Dorsey Lyon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 19, 1940
Nov. (Month) 19 (Day) (Year) 19

17 I HEREBY CERTIFY, That I attended the deceased from ____ 192__ to ____, 192__,
that I last saw h__ alive on ____, 192__,
and that death occurred on the date stated above, at ____ m.
The CAUSE OF DEATH * was as follows:

Still born infant

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. Henry Dr. Hodgson M. D.

192__ (Address) ____

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Old County Cemetery	Nov 19, 1940
20 UNDERTAKER	ADDRESS
George Marble (father)	Midland

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Baltimore, requesting V. S. No. 1.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V S No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

RECEIVED DEC 6 1940

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WITHIN CORPORATE LIMITS

Dr. Gatten

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11255

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Centennial St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna Lucinda McKenzie

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): not known

8. AGE: Years: 71 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Garrett County, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Francis McKenzie
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah M. Garlitz
15. Birthplace: Maryland

16. Informant: George McKenzie
Address: Frostburg, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 2, 1940
(month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. Dec. 2 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-29 1940, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 4 1940, to Mar. 20 1940 and that I last saw her alive on March 20 1940.

Immediate cause of death: Cardio-Vascular Renal Disease with Hypertension

DURATION: 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. E. Gatten M. D. or other

Address: Frostburg, Md. Date signed: 12/2/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11256

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 50 Centennial St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Henry McKenzie
3.(b) Social Security Number: 220-10-2101

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Anna Warner
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Sept 13, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	1	21		

9. Birthplace: Somerset Co., Pa.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Fire Clay Mines
FATHER 12. Name: Francis McKenzie
13. Birthplace: Somerset Co, Pa
MOTHER 14. Maiden name: Leah Warner
15. Birthplace: Somerset Co, Pa
18. Informant: Mrs. Edna McKenzie
Address: 50 Centennial St, Frostburg
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6 1940 (month) (day) (year)
Cemetery or crematory: Greenville
Location: Greenville, Pa.
18. Funeral director: Jacob Hafer
Address: Frostburg, Md.
19. Nov. 4 1940 (Date rec'd by registrar) M. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1940, at 4 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1940, to Nov. 3 1940
and that I last saw him alive on Nov. 3 1940.

	DURATION
Immediate cause of death: Cardio-vascular renal disease	
Due to:	
Due to:	
Other conditions: Chronic Prostatitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other
Address: Frostburg, Md. Date signed 11-4-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 11257 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 hrs

Hospital, institution, or street address where death occurred: Miners Hosp -

How long in hospital or institution? 14 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Penn County: Somerset

City or town: Meyersdale Pa RFD3 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Samuel Joshua McKenzie

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Armada Elis McKenzie

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 29 1870

8. AGE: Years	Months	Days	If less than one day
70	7	11	hrs. min.

9. Birthplace: Meyersdale Pa (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Francis McKenzie

13. Birthplace: Meyersdale Pa

MOTHER — 14. Maiden name: Leah McKenzie

15. Birthplace: Meyersdale Pa

18. Informant: Harold McKenzie

Address: Meyersdale Pa RB

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14-1940 (month) (day) (year)

Cemetery or crematory: Catholic Cem

Location: Pocahontas Pa.

18. Funeral director: Jos. F. Reisle

Address: Meyersdale - Pa.

19. Nov. 11th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1940 at 11.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1940 to Nov 11 1940

and that I last saw h- alive on Nov 11 1940

Immediate cause of death	INTERVAL	DURATION
Congestive Heart failure + Chr. myocarditis		
Due to		
Due to		
Other conditions: Incarcerated Diaphragmatic Hernia - (Include pregnancy within 3 months of death)		

Major findings of operations: Incarcerated diaphragmatic hernia Date of op. 11-10-40

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A M Earl Jr MD M. D. or other

Address: 60 W Main St Frostburg Md Date signed: Nov 11 1940

RECEIVED
DEC 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 yrs

Hospital, institution, or street address where death occurred: 216 Saratoga St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Saratoga St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Roy Martin

3. (b) Social Security Number 705-10-6039

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Nellie M. Morgan

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 12 1889

8. AGE: Years 51 Months 7 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Billing Agent

11. Industry or business: W. Md R.R.

FATHER 12. Name: Marcellus Martin

13. Birthplace: Hancock Md

MOTHER 14. Maiden name: Alice Kelly

15. Birthplace: Pa.

18. Informant: Arthur Martin

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 '40 (month) (day) (year)

Cemetery or crematory: St Peters & Pauls Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Nov 12 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1940 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-10-40 19 to 11-10 1940 and that I last saw him alive on 11-10-40 19

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: O. S. Emmerman M.D. M. D. or other

Address: Cumberland Md Date signed 11-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 20 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1316) CB

CERTIFICATE OF DEATH

Reg. Dist. No. 11258

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State OHIO County

City or town CINCINNATI.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 947 COURT ST.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
BEAUFORD MILLER

3. (b) Social Security Number
705-09-9137

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	BLACK	MARRIED

6.(b) Name of husband or wife CLARA RICHARDSON

6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) JUNE 10 1893

8. AGE: Years	Months	Days	If less than one day
47	5	1	hrs. min.

9. Birthplace KENTUCKY
(Town, county, and state)

10. Usual occupation COOK BALTIMORE & OHIO

11. Industry or business RAILROAD CO.

FATHER
12. Name WILLIAM MILLER
13. Birthplace KENTUCKY

MOTHER
14. Maiden name MARY HUBBARD
15. Birthplace KENTUCKY

16. Informant SELF (TIME OF ADM.)

Address 947 COURT ST., CINCINNATI, OHIO

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 18, 40 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cincinnati Ohio

18. Funeral director Louis Stein Inc.

Address Cumberland Md

19. Nov. 14, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W. F. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 12, 1940 19 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-19-1940 to 11-12-1940 and that I last saw him alive on 11-11-1940

Immediate cause of death

	DURATION
Chronic Myocarditis	
Chronic Nephritis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

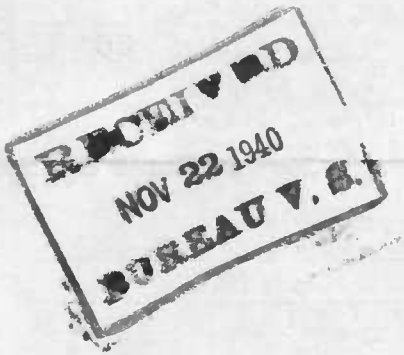
23. SIGNATURE Wm. F. Williams M. D. ~~or other~~

Address Cumberland Date signed 11-12-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
NOV 22 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (81-6)

11259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Flintstone (Rural) Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Myrtle Morgan

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1924

8. AGE: Years 16 Months 4 Days 14 If less than one day hrs. min.

9. Birthplace Greenridge, Md. (Town, county, and state)

10. Usual occupation Student.

11. Industry or business

FATHER 12. Name David Morgan

13. Birthplace Maryland

MOTHER 14. Maiden name Cora Gordon

15. Birthplace Md.

16. Informant David Morgan

Address Flintstone, Md.

17. Burial Date thereof Nov. 22, 1940 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Green Ridge, Md

Location Near Flintstone

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. Nov 20 1940 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1940, at 11:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18 1940, to Nov 19 1940, and that I last saw her alive on Nov 19 1940.

Immediate cause of death Cerebro-Spinal Meningitis;

Due to Type not determined; no organisms found in spinal fluid. Cell count, 380 per Cm. C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. B. Mathews M. D. or other

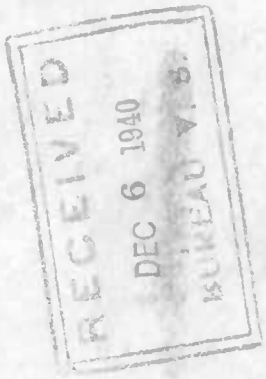
Address 122 So Central St Date signed 2880

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

July 5, 1924



WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

11260

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 29 S Centre (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Walter Grant Morris

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Belle Smouse Morris

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 17, 1863

8. AGE: Years 77 Months 5 Days 26 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Telegrapher

11. Industry or business Western Union

FATHER 12. Name John Morris

13. Birthplace Cumberland Md

MOTHER 14. Maiden name Mary Deitz

15. Birthplace Cumberland Md

16. Informant Belle Morris

Address 29 S. Centre St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Nov. 14 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1940 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1940 to Nov 13 1940 and that I last saw him alive on Nov. 13 1940

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions Phlebitis Rt Leg.

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L B Mathews, M.D. M. D. or other

Address 122 So Centre St Date signed 2880

Mathews

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

11261

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Midland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 41 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Elizabeth Robertson Muir

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William C. Muir

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 1st 1853

8. AGE:

Years	Months	Days	If less than one day
87	1	7	— hrs. — min.

9. Birthplace Lonaconing, Md (Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER 12. Name David Robertson

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden name Jean Gordon

MOTHER 15. Birthplace Scotland

16. Informant Mrs. George Kroll

Address Gilmore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1940 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md

18. Funeral director M. Eichhorn

Address Lonaconing, Md

19. Nov 10 1940 (Date rec'd by registrar) E. Oma Pyle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15th 1940, to Nov. 8 1940, and that I last saw h[er] alive on Nov. 7 1940

Immediate cause of death	Cerebral Hemorrhage	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Lonaconing, Md Date signed Nov. 9 '40

RECEIVED
DEC 6 1940
BUREAU V. S.

M

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11262

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Peakin Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Peakin Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Still birth

3. (b) Social Security Number

4. Sex F

5. Color or race W.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Nov 17, 1940

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Still birth

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Peakin Md (Allegany)

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Lester Allen Munson

13. Birthplace Peakin Md

MOTHER

14. Maiden name Bessie Jane Kitty

15. Birthplace Peakin Md.

16. Informant Parents

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 17, 1940

(month) (day) (year)

Cemetery or crematory Moscow Cemetery

Location Moscow, Md.

18. Funeral director Mr. Erickhorn

Address Lonaconing, Md.

19. Nov 17 1940

(Date rec'd by registrar)

S. A. Boucher

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17, 1940, to Nov. 17, 1940

and that I last saw h..... alive on 19

Immediate cause of death Still birth

Due to Lues

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L W Reeves

M. D. or other

Address Westernport Md

Date signed 11-18-40

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

Dr. Kilday

Reg. Dist. No. 11263 9

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Laing Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Elizabeth Murphy

3. (b) Social Security Number None

4. Sex	5. Color or race	b.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife John Murphy 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1880

8. AGE: Years	Months	Days	If less than one day
60	1	2	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER 12. Name Frank Murphy
13. Birthplace Germany

MOTHER 14. Maiden name Amelia Schultz
15. Birthplace Germany

16. Informant Mrs. Joseph Breeland
Address Frostburg, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Dec. 3 1940 (month) (day) (year)
Cemetery or crematory St. Peters & Pauls Cemetery
Location Cumberland Md.

18. Funeral director J. J. Durst
Address Dec. Frostburg, Md.

19. Dec. 2nd 1940 (Date rec'd by registrar) Mrs. V. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/40 19 at 7 50/A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/20/40 19 to 11/30/40 19 and that I last saw her ALIVE on 11/30/40 19

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Portal Cirrosis	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op. none
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none
Accident, suicide, or homicide none Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury none Injured at work?

23. SIGNATURE John Kilday M.D.
M. D. or other
Address Frostburg, Md. Date signed 12/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 3 1941
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80-L)

11264

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mo.

Hospital, institution, or street address where death occurred: 607 Greene Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rt #5. Potomac Park Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural near Cumberland.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Michael James Murray Jr.

3. (b) Social Security Number: —

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Child

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 16, 1939

8. AGE: Years: 0 | Months: 11 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Michael James Murry Sr.
13. Birthplace: Thomas, W. Va.

MOTHER
14. Maiden name: Helen Nesbitt
15. Birthplace: Deer Park, Maryland

16. Informant: Michael J. Murry Sr.
Address: Rt #5. Potomac Park, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 2, 1940 (month) (day) (year)

Cemetery or crematory: St. Peter's & St. Paul's Cem.

Location: Cumberland, Maryland

18. Funeral director: Jacob Hafer
Address: Cumberland, Md.

19. 12-2 1940 (Date rec'd by registrar) Joseph P. Franklin, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1940, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 1940, to November 30 1940 and that I last saw him alive on November 30 1940

Immediate cause of death	DURATION
Cerebral Convulsions	3 days.
Due to: Strumpell-Marie Disease (Encephalitis)	? ? ?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other

Address: 119 Bedford St. Date signed: 12/2/40

Dr. Jacobson

VS A15 (T) (I) (C) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

11265

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Allegany Hosp.

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Queen City Pavement
(If rural, give LOCATION)

2.(a) If veteran, name war: 1914 - to 1919

3. (a) FULL NAME Arthur Nesbitt

3. (b) Social Security Number 220-10-0689

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: Mae Humbertson

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 52 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: West Va
(Town, county, and state)

10. Usual occupation: Taxi Chauffeur

11. Industry or business: Transportation

FATHER
12. Name: Wm Nesbitt
13. Birthplace: West Va

MOTHER
14. Maiden name: Mary
15. Birthplace: West Va

16. Informant: Mrs Mae Nesbitt

Address: Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. ~~Sept~~ 29-40 (month) (day) (year)

Cemetery or crematory: Lion Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: V. L. Lemperer

Address: Cumberland, Md.

19. Nov 28 1940 (Date rec'd by registrar) Joseph P. Franklin, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25th., 1940, at 6.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage (Apoplexy)	instant death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lynne H. Conon, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 11/26/40

Deputy Medical Examiner - Allegany Co.

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2) Lyle B. Newhouse 11266

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: near Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Mineral
City or town: Keyser
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 99 B St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lyle Bernard Newhouse

3.(b) Social Security Number: 220-10-4829

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1915

8. AGE:

Years	Months	Days	If less than one day
25	8	27	..... hrs. ..... min.

9. Birthplace: Keyser, Mineral, W. Va.
(Town, county, and state)
10. Usual occupation: Coning
11. Industry or business: Celenese Corporation
FATHER 12. Name: E. D. Newhouse
13. Birthplace: Moorefield, W. Va.
MOTHER 14. Maiden name: Sallie Clower
15. Birthplace: Moorefield, W. Va.
16. Informant: Mrs. E. D. Newhouse
Address: Keyser, W. Va.
17. burial (Burial, cremation, or removal. Which?) Date thereof 11/23/40 (month) (day) (year)
Cemetery or ~~crematory~~: Queen's Point
Location: Keyser, W. Va.
18. Funeral director: J. H. Markwood Sons
Address: Keyser, W. Va.
19. Nov. 23 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20th., 1940, at about 8.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra-cranial hemorrhage	Instant death
Due to: Slight contusion 2 inches back of left ear. No fracture of skull.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Intracranial hemorrhage.

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Case being investigated by States Attorney Date of 11/20/40
Where did injury occur? Near Westernport, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Probaby along highway.
Means of injury unknown at present Injured at work? no

23. SIGNATURE: Pierce H. Courtney, M. D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 11/22/40
Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 5 1940
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11267

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Md. Route 220 RFD #5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Circle Inn Route 220 RFD #5
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Circle Inn Route 220 RFD #5
Cumberland (If rural, give LOCATION) Md.
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Northup

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Harold Northup
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 27, 1894

8. AGE: Years	Months	Days	If less than one day
46	2	24	hrs. min.

9. Birthplace Elk Garden, West Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Nelson Duckworth
13. Birthplace md
MOTHER 14. Maiden name Mary Spanker
15. Birthplace Germany
16. Informant Mrs Harold Northup
Address Lonaconing, Md. R F D 5
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-24-40 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.
18. Funeral director Louis Steinberg
Address Cumberland, Md.
19. Nov. 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-40 1940 at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Jan attended, to 1940
and that I last saw h alive on 1940
Immediate cause of death Cardiac Failure — DURATION
Patient was dead on arrival
Due to Patient dead on arrival Cause R
Coronary Thrombosis Dr. W. O. McLaney, Frostburg
Due to no more obtainable
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ness, M.D.
M. D. or other
Address Frostburg, Md. Date signed 11-22-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

11268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 221 THOMAS STREET (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. JAMES ELWOOD PARSONS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife HANNAH BLUE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1887

8. AGE: Years 53 | Months 3 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation UNEMPLOYED*UNABLE TO WORK

11. Industry or business

FATHER 12. Name EDGAR ELWOOD PARSONS

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name ANNA SHANNON

15. Birthplace WEST VIRGINIA

16. Informant James R Parsons

Address 221 Thomas St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30, 1940 (month) (day) (year)

Cemetery or crematory Springfield Cem.

Location Springfield W. Va.

18. Funeral director Louis Stein Esq.

Address Cumberland, Md

19. Nov 27 1940 (Date rec'd by registrar) Joseph P Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27- 1940, at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-26- 1940, to 11-27- 1940 and that I last saw him alive on 11-26- 1940

Immediate cause of death Broncho Pneumonia — DURATION ?

Due to In Hospital twelve

Due to hours

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 11-27-40

DR. W. F. WILLIAMS

VS A15 (T) (I) (M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

11269

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few minutes
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? Short While (Emergency)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: Allegany
City or town: Cresaptown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war: World War

3.(a) FULL NAME: George P Pfister

3.(b) Social Security Number: 217-01-7028

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Cherry
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 18. 1888

8. AGE: Years	Months	Days	If less than one day
52	5	17	..... hrs. ..... min.

9. Birthplace: Eckart Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Stone Crusher
FATHER 12. Name: Carl Pfister
13. Birthplace: Germany Hanover
MOTHER 14. Maiden name: Catherine Haverath
15. Birthplace: Germany
16. Informant: Mrs G Evelyn Pfister
Address: Cresaptown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7 40 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetery
Location: Eckhart, Md.
18. Funeral director: Lewis Stein Inc.
Address: Cumberland, Md.
19. Nov 6 1940 (Date rec'd by registrar) J P Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5th., 1940, at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Crushed left chest (fractured left clavicle, fractured upper eight ribs, anteriorly)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 11/5/40
Where did injury occur? Cresaptown, Allegany, Maryland. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Stone Quarry
Means of injury: truck backed over him Injured at work? yes

23. SIGNATURE: Bruce H. Brown M. D. (M. D. or other)
Address: Cumberland, Maryland. Date signed: 11/6/40
Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 14 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11270

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Va. County: Mineral

City or town: Ridgely

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Blocker St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Pope, Blanche

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband ~~or wife~~: Charles A. Pope

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1889

8. AGE:

Years	Months	Days	If less than one day
51	9	14	..... hrs. ..... min.

9. Birthplace: Piedmont W. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Charles A. Pope

Address: Blocker St. Ridgely W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1940 (month) (day) (year)

Cemetery or crematory: Summit Cem.

Location: Cumberland, Md.

18. Funeral director: J. C. Walford

Address: Cumberland, Md.

19. Nov 4 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 1940, at 11:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1940, to Nov 2 1940 and that I last saw h.. alive on Nov 2 1940

Immediate cause of death	DURATION
(1) Pulmonary Embolism	
Due to (2) Chronic Nephritis	
Due to (3) Arteriosclerosis	
Other conditions (4) Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. A. Mathews M.D. M. D. or other

Address: 112 So. Centre St. Date signed: Nov. 8-40.

VS A15 (T) (I) (M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

Dr. McLane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 11271 9

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Elizabeth Porter

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Walter W. Porter

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 25, 1882

8. AGE: Years 58 | Months 4 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace: Eckhart Md - Allegany Cty.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: George Brunner
13. Birthplace: Eckhart, Md

MOTHER
14. Maiden name: Elizabeth Kirby,
15. Birthplace: Eckhart, Md.

16. Informant: Mrs. Raymond Hanna,
Address: Frostburg, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 19-1940
(month) (day) (year)

Cemetery or crematory: Porter cemetery

Location: Eckhart, Md.

18. Funeral director: J. J. Durst,
Address: Frostburg Md.

19. Nov. 19 1940
(Date rec'd by registrar)
Mrs. A. P. Walker
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1940, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to Nov 17 1940 and that I last saw her alive on Nov 10 1940

Immediate cause of death: Chronic Myocarditis — DURATION: 1 yr

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md — Date signed: 11-18-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-a)

11272

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 Virginia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Francis Powell

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Michael R. Powell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 20 1891

8. AGE: Years 49 | Months 9 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Dry Fork W. Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER
12. Name: John O'Haver
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Rachael Starkey
15. Birthplace: W. Va.

16. Informant: John B. Powell
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 8 '40 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Rural Cumberland.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. Nov. 8, 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1940, at 7 o'c M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/6/40 19..., to 11/5 1940 and that I last saw her alive on 11/5/40 19...

Immediate cause of death: Pelvic inflammation

Due to: — The colostomy was performed for pelvic abscess; and not for cancer.

Due to: — There was no cancer. W.G.R.

Other conditions: Colostomy.

(Include pregnancy within 3 months of death)

Major findings of operations: Large pelvic abscess perilaunts Date of op. 7/6/40

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John H Rozum M.D. — M. D. or other

Address: Cumberland Ave Date signed 11/6/40

VS A15 (I) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Dr. Gatten
11273 9
Reg. Diat. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 141 Bowery St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: David Howell Powell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1857

8. AGE: Years	Months	Days	If less than one day
82	10	20	..... hrs. ..... min.

9. Birthplace: Mt. Savage, Md. (Town, county, and state)
10. Usual occupation: Miner - retired
11. Industry or business: Coal mines
FATHER
12. Name: Howell Powell
13. Birthplace: Wales
MOTHER
14. Maiden name: —
15. Birthplace: —
16. Informant: Joseph James
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1940 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: J. J. Durst
Address: Frostburg, Md.
19. Nov 3rd 1940 (Date rec'd by registrar) Mrs. K. P. Tucker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1940, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 1940 to Nov. 1 1940
and that I last saw h. l. alive on Oct. 31 1940

Immediate cause of death	DURATION
Bronchial Asthma	12 hours
Due to: C-V-R Disease	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. E. Gatten M.D.
M. D. or other
Address: Frostburg, Md. Date signed: 11/1/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 9 1940
BUREAU V. B.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

11274

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred: 811 Mt Royal
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 811 Mt. Royal Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence E. Powell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Virgil Powell
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): September 18, 1886

8. AGE: Years	Months	Days	If less than one day
56	1	15	hrs. min.

9. Birthplace: Germantown, Pa.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: Frederick Elbridge
13. Birthplace: Germantown, Pa.
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Virgil Powell
Address: 811 Mt. Royal Ave.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland, Maryland
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. Nov 4 1940 (Date rec'd by registrar) Joseph Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2nd., 1940, at about 11.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Suicide	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 11/2/40
Where did injury occur? Cumberland (City or town) Allegany (County) Maryland. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: hanging Injured at work? no

23. SIGNATURE: Pierce H. Brown M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 11/4/40

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11275

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks 4 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 40 Bedford St (If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME Charles Edward Ralston

3. (b) Social Security Number 205-14-0105

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Zona 'Vainer' Ralston

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): May 29, 1904

8. AGE: Years 36 Months 5 Days 12 If less than one day ... hrs. ... min.

9. Birthplace: Keyser W.Va. (Town, county, and state)

10. Usual occupation: Machinist Helper

11. Industry or business: Artificial Silk Mill

FATHER
12. Name: Charles E Ralston
13. Birthplace: Keyser, W.Va.

MOTHER
14. Maiden name: Nellie Lanzote
15. Birthplace: Martinsburg W.Va.

16. Informant: Zona Ralston

Address: 40 Bedford St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 14, 1940 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland, Md

18. Funeral director: Jacob Hofer

Address: Cumberland

19. Nov. 14, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1940, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15, 1940, to Nov. 11, 1940 and that I last saw him alive on Nov. 11, 1940

Immediate cause of death: Coronary Thrombosis - sudden

Due to: Duodenal Ulcer — DURATION: 6 mo.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. C. Zimmerman M.D. M. D. or other

Address: 105 S. Centre St Cumberland, Md. Date signed: 11-13-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

11276

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 618 Baltimore Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 618 Baltimore Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Raupach

3. (b) Social Security Number None

4. Sex: Female.
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 5, 1940
8. AGE: Years | Months | Days 3 | If less than one day hrs. min.
9. Birthplace Cumberland, Allegany, Md (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name James M. Raupach
13. Birthplace Philson Penna.

MOTHER
14. Maiden name Besse Wratchford.
15. Birthplace Ellamore W. Va.

16. Informant James M. Raupach
Address 618 Baltimore Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1940 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetary
Location Cumberland. Maryland.
18. Funeral director V. L. Lempereur
Address 202 Greene St. Cumberland Md
19. Nov. 9, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1940, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Nov. 8 1940, to Nov. 8 1940 and that I last saw her alive on Nov. 8 1940.
Immediate cause of death Premature birth
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. S. Owen M. D. or other
Address 133 Va Date signed Nov. 8 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. B.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

11277

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Seibert
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME REID, SARA E. MRS.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife F. ERNEST REID
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 12, 1889

8. AGE: Years	Months	Days	If less than one day
51	8	1	hrs. min.

9. Birthplace MD. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name Samuel Tipton
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Lucy Davis
15. Birthplace West Virginia
16. Informant Frank Ernest Reid
Address Seibert

17. burial (Burial, cremation, or removal. Which?) Date thereof November 16, 1940 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Maryland
18. Funeral director Louis Stein Inc.
Address Cumberland, Maryland

19. Nov. 15 1940 J. L. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 13, 1940, at 12:08 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13 1940 to Nov 13 1940
and that I last saw h[illegible] alive on Nov. 13 1940

Immediate cause of death	DURATION
Valvular heart disease	about 1935
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury No Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 133 Va Ave Date signed 11/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11279

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 25 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 609 HILLTOP DRIVE (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY NORMA RIDER

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4, 1940

8. AGE: Years	Months	Days	If less than one day
	4	3	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation BABY

11. Industry or business

FATHER 12. Name JOHN S. RIDER

13. Birthplace MARYLAND

MOTHER 14. Maiden name LAVERNE AMBROSE

15. Birthplace MARYLAND

16. Informant John S Rider

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Paw Paw W Va.

18. Funeral director Louis Stein Sons

Address Cumberland Md

19. NOV 8 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 7 1940 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1940 to Nov. 7 1940 and that I last saw h.er alive on Nov. 7 1940

Immediate cause of death	DURATION
Bronchio-pneumonia	
Due to, or as a consequence of	
Due to, or as a consequence of	
Other conditions Probable acute toxic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Royce Hodges M. D. or other

Address Date signed

Helen S - DR. GROVE

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

CERTIFICATE OF DEATH

11280

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 21 days.

Stay in this community (yrs. or mos. or days): Alms House 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ~~Allegany County Home.~~ (If rural give LOCATION) 115 Offutt St.

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Ripper.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: ~~Barbara Elizabeth~~ Hughes

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1865 ~~1868~~

8. AGE:

Years	Months	Days	If less than one day
75.	0	11	____ hrs. ____ min.

9. Birthplace: Sandy Hook, Maryland (Town, county, and state)

10. Usual occupation: No Information to be had

11. Industry or business

FATHER — 12. Name

13. Birthplace

MOTHER — 14. Maiden name

15. Birthplace

16. Informant: Alms House

Address: Valley Rd., Nr. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25/40 (month) (day) (year)

Cemetery or crematory: Allegany County

Location: Alms House

18. Funeral director: Davis Stein Inc.

Address: Cumberland

19. Nov. 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-22-1940, at 10:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1-1940 to 11-22-1940 and that I last saw him alive on 11-22-1940.

Immediate cause of death	DURATION
Arteriosclerosis.	
Chronic Myocarditis	?
Due to Cerebral Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed 11-23-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

11281

Reg. Dist. No. 7

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Alleganey
City or town: 7 mi. East of Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Barton- rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 mi. East of Barton
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Lee Ross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Ester Ross
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1863

8. AGE: Years	Months	Days	If less than one day
77	4	0	hrs. min.

9. Birthplace: Oldtown, Allegany-Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own farm

FATHER
12. Name: Henry Ross
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Lucindia Magruder
15. Birthplace: Barton, Md.

16. Informant: Floyd Ross
Address: Dawson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10, 1940 (month) (day) (year)
Cemetery or crematory: Llewellyn cemetery
Location: 5 mi. East of Barton.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. Nov 9 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8, 1940 19 at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st 1940 to Nov 8 1940
and that I last saw h alive on Nov 1st 1940

Immediate cause of death: Valvular disease of heart — DURATION

Due to:

Due to:

Other conditions: Uremia

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry Dr. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed: Nov 9th 1940

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

11282 9

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 128 Wood St.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: 128 Wood St. - Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Elizabeth Rupp.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: Carl Rupp.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 28 - 1855.

8. AGE: Years	Months	Days	If less than one day
85	0	13	..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Nicholas
13. Birthplace: Germany

MOTHER
14. Maiden name: unknown.
15. Birthplace

16. Informant: John Rupp.
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13 - 1940 (month) (day) (year)

Cemetery or crematory: German Lutheran

Location: Frostburg.

18. Funeral director: J. J. Dwist.

Address: Frostburg, Md.

19. Nov. 12 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 1940, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1940, to Nov 10 1940 and that I last saw her alive on Nov 10 1940

Immediate cause of death: Lobar Pneumonia — DURATION: 3 Day

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md. Date signed: 11-11-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

11283

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Rural – Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? – [redacted] –

Hospital, Institution, or street address where death occurred:
2 mi East or U.S. 40 – Wanner's Gas Station

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 120 Virginia ave.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Henry J. Ryan

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie Homburger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 1, 1877

8. AGE:

Years	Months	Days	If less than one day
63	1	26	..... hrs. ..... min.

9. Birthplace: Lowery's Creek Pennsylvania
(Town, county, and state)

10. Usual occupation: attendant

11. Industry or business: Gas Station

FATHER
12. Name: George Ryan
13. Birthplace: Pa.

MOTHER
14. Maiden name: Tillie Rayan
15. Birthplace: Pa.

16. Informant: Nettie Homburger
Address: 120 Va. ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Mavis Crossroads

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland

19. Nov 28 1940 (Date rec'd by registrar) Joseph P. Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1940, at 8:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1940, to Nov. 26 1940 and that I last saw him alive on Nov. 26 1940

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs
Due to: Coronary occlusion	1/2 day
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: W Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Va ave Date signed: 11/27/40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

11284

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 624 SHRIVER AVENUE (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DAVID F. SCHUTZ

3.(b) Social Security Number 213-01-6076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BESSIE WILLIAMS SCHUTZ

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) MARCH 31, 1891

8. AGE: Years	Months	Days	If less than one day
49	7	16	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation SALESMAN--

11. Industry or business ORT BROS. BAKERY

FATHER 12. Name FRANK SCHUTZ

13. Birthplace MARYLAND

MOTHER 14. Maiden name CLARA BOWEN

15. Birthplace MARYLAND

16. Informant Memorial Hospital

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md

18. Funeral director Jacob Hafer

Address Cumberland, Md

19. Nov. 19 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W.F. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 16, 1940, at 6:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-25-38 19 , to 11-16-1940

and that I last saw him alive on 11-16-1940

Immediate cause of death: Chronic Nephritis c Hypertension (uremia)

Due to

Due to

Other conditions

DURATION: 2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams M. D. or other

Address Cumberland Date signed 11-16-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-d)

11285

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Henry Shroyer

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Griffith

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept. 4 1867

8. AGE:

Years	Months	Days	If less than one day
73	2	14	hrs. min.

9. Birthplace Bedford County, Pa.

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER

12. Name Mose Shroyer

13. Birthplace Penna.

MOTHER

14. Maiden name Mary Logsdon

15. Birthplace Penna.

16. Informant George I. Shroyer

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21 1940 (month) (day) (year)

Cemetery or crematory Porter

Location Hyndman, Pa. R.F.D. #1

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. Nov 20 1940 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18. 1940, at 6 P 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Nov 18 1940, and that I last saw h 1st alive on Nov 18 1940.

Immediate cause of death Hypertensive Arterio-Sclerotic Heart Disease

DURATION 1930.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A Topper MD. M. D. or other

Address Hyndman Pa Date signed 11/18/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 8 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11286

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners' Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 170 Center St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Louis Skidmore

3. (b) Social Security Number: 220-10-2271

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Frances Skidmore
6(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): January 9, 1907

8. AGE:

Years	Months	Days	If less than one day
33	10	6	hrs. min.

9. Birthplace: Midlothian, Md. (Town, county, and state)
10. Usual occupation: Timekeeper
11. Industry or business: W.P.A.
12. FATHER — Name: Louis Skidmore
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Martha Drew
15. MOTHER — Birthplace: Maryland
16. Informant: Edgar Skidmore
Address: Midlothian, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 17-1940 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg, Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. Nov. 17 1940 (Date rec'd by registrar) Mrs. A. P. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1940, at 11:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1940, to Nov. 15 1940
and that I last saw him alive on Nov. 15 1940

Immediate cause of death	DURATION
Diabetes mellitus	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: X
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D.
M. D. or other
Address: Frostburg, Md. Date signed 11-15-40

RECEIVED
DEC 3 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11287

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 wks

Hospital, Institution, or street address where death occurred: 178 No. Centre St.

How long in hospital or institution? 10 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 178 No Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Leona Mae Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 30 - 1940

8. AGE: Years — Months 1 Days 27 If less than one day — hrs. — min.

9. Birthplace: Maryland - Cumberland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Lloyd Smith

13. Birthplace: Maryland

MOTHER 14. Maiden name: Audrey Holliday

15. Birthplace: W. Va.

16. Informant: Lloyd Smith

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 24-40 (month) (day) (year)

Cemetery or crematory: Fairview, Md.

Location: Fairview, Md.

18. Funeral director: V. L. Feinberg

Address: Cumberland, Md.

19. Nov 23 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22 1940, to Nov. 22 1940

and that I last saw h... alive on Nov. 21 1940

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Pertussis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. G. Bowers M. D. or other

Address: 133 Valley Date signed: 11/22/40

RECEIVED
DEC 6 1940
BUREAU V. B.

Outside of (M) City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

11288

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural - Green Ridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural - Green Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Baby Boy Snyder (Stillborn)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: No

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: ..... hrs. 0 min.

9. Birthplace: Green Ridge, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Eugene Preston Snyder
13. Birthplace: Green Ridge Md

MOTHER
14. Maiden name: Edith Grace Twigg
15. Birthplace: Little Orleans, Md.

16. Informant: Eugene P. Snyder
Address: Green Ridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30 40 (month) (day) (year)

Cemetery or crematory: Spring Gap Cem
Location: Spring Gap, Md.

18. Funeral director: Emmitt Twigg (Sexton)
Address: Old Town, Md.

19. Nov 29 40 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 1940 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Stillborn	DURATION
Due to:	
Due to:	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) No
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph P. Franklin M.D. F.T.D.S. M. D. or other
Address: Cumberland Md. Date signed 11-29-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (2)

Reg. Dist. No. 8

11289

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Lonaconing Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Alleg.

(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town)

(d) Street No. —
(If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Zaby Stafford

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1940

8. AGE: Years — Months — Days — If less than one day — hr. — min.

9. Birthplace Lonaconing Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Alex Stafford
13. Birthplace Lonaconing Md.

MOTHER
14. Maiden Name Florence Jeffries
15. Birthplace Lonaconing Md.

16 (a) Informant Mrs. Alex Stafford
(b) Address Lonaconing Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1940 (month) (day) (year)

(c) Cemetery or crematory Laurel Hill Cemetery

Location Moscow Md.

18 (a) Funeral director M. Eichhorn

(b) Address Lonaconing, Md.

19 (a) Nov. 20 (Date rec'd by registrar) (b) E. Don Tyler Registrar

MEDICAL CERTIFICATION

20. Date of death Nov. 16 1940, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 , and that I last saw him alive on — 19 .

Immediate cause of death Still born infant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Henry M. Hodgson M.D. M. D. or other

Address Lonaconing Md Date signed Nov. 17 40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11290

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 219 Lahley St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 219 Lahley St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Charles Stakem Sr.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Alice Portland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 16 1878

8. AGE: Years: 62 | Months: 8 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Ocean, Md.
(Town, county, and state)

10. Usual occupation: Bowling Alley - Co-Owner

11. Industry or business: Savoy Bowling Alleys

FATHER
12. Name: John Stakem
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Ellen Cullen
15. Birthplace: Ireland.

16. Informant: Mrs Thomas C Stakem Sr
Address: Cumberland. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-40 (month) (day) (year)

Cemetery or crematory: St Peter & Paul

Location: Cumberland. Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland, Md.

19. 11-23 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20, 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion - sudden	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: O C Zumwalt M. D. or other

Address: 105 S. Centre St. Cumberland, Md. Date signed 11-22-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

CERTIFICATE OF DEATH

11291

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs.
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 N. CHASE ST., CITY
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. ELIZABETH M. STEELE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife MILLARD F. STEELE
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) MARCH 30 1868

8. AGE: Years	Months	Days	If less than one day
72	7	2	...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation HOUSEWORK
11. Industry or business At Home
FATHER 12. Name Anthony Winkle
13. Birthplace Germany
MOTHER 14. Maiden name Elizabeth Weyman
15. Birthplace Germany
16. Informant Mrs Geo. K Steiner
Address Cumberland
17. Burial, cremation, or removal. Which? Burial Date thereof Nov 5 40 (month) (day) (year)
Cemetery or crematory St. Peter & Paul's Cem
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19. Nov 5 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 2 1940 at 11:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to November 2 1940 and that I last saw h... alive on November 2 1940

Immediate cause of death	DURATION
Peritonitis	
Sepsis	
Due to Cholecystectomy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Gangrenous Gall Bladder
Gall Stones Date of op. October 29, 40
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other
Address 41 Grant St Date signed November 4 1940
DR. SCHINDLER

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

11292

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
508 Boyd Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 508 Boyd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Harry Alexander Tantlinger

3.(b) Social Security Number 212-10-6226

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Maude Wright Tantlinger 6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 9, 1883

8. AGE: Years	Months	Days	If less than one day
57	6	14	..... hrs. ..... min.

9. Birthplace Mt. Pleasant Pa.
(Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Auto Garage
FATHER 12. Name Samuel Tantlinger
13. Birthplace Mt. Pleasant Pa.
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Maude Tantlinger
Address 508 Boyd St Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25 1940 (month) (day) (year)
Cemetery or crematory Sylvan Heights
Location Uniontown Pa.
18. Funeral director Jacob Yates
Address Cumberland
19. Nov 25 1940 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1940 at 7:45A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 15, 1940 to November 23 1940 and that I last saw h... im alive on October 22, 1940

Immediate cause of death	DURATION
Pulmonary hemorrhage is not due to tuberculosis, cured.	10 min.
Due to Arterial hypertension	Indef.
The pulmonary hemorrhage was not	
Due to due to tuberculosis, but to the	
arterial hypertension.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. W. Wales M. D.
M. D. or other
Address Cumberland, Md. Date signed 11-25-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

11293 9

Reg. Dist. No. 1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Rural - Near Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No. None, Rural Frostburg, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laird Walter Thomas

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 1924

8. AGE: Years 16 | Months 2 | Days 13 | If less than one day hrs. min.

9. Birthplace Eckhart Allegany, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business School Child

FATHER 12. Name Clarence Thomas

13. Birthplace Frostburg, Md

MOTHER 14. Maiden name Angie Rinaldo

15. Birthplace Pittsburgh, Pa.

16. Informant Clarence Thomas

Address Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14 1940 (month) (day) (year)

Cemetery or crematory Eckhart Cem

Location Eckhart, Md

18. Funeral director Jacob Dafler

Address Frostburg, Md.

19. Nov. 12 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

	DURATION
Immediate cause of death fracture of base - contusion of brain.	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-11-40

Where did injury occur? Eckhart, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury struck by auto Injured at work? no

23. SIGNATURE Pierce H. Dawson, M. D.
M. D. or other

Address Cumberland, Md. Date signed 11-12-40

Deputy Medical Examiner - Allegany Co.

RECEIVED
DEC 3 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

11294

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ~~Valley Rd~~ R.F.D. Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 11 ~~mos~~ wks da.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Valley Rd. R.F.D. (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Jane L. Twigg

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband ~~or wife~~: Charles E. Twigg

6. (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1872

8. AGE: Years: 68 Months: ~~10~~ Days: ~~10~~ If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Henry Leighty

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca Knight

MOTHER 15. Birthplace: Maryland

16. Informant: Charles E. Twigg

Address: Cumberland, Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Zion Memorial Park

Location: Bedford Rd. Cumberland, Md

18. Funeral director: V. L. Lemperan

Address: Cumberland, Md.

19. Dec 3 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30, 1940, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29, 1940, to Nov 30 1940, and that I last saw h~~er~~ alive on Nov. 30, 1940.

Immediate cause of death	DURATION
Bronchial Pneumonia	1 wk.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. B. Moore M.D.

M. D.

Address: Medical Bldg. Date signed 12/2/40

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117a

CERTIFICATE OF DEATH

11295

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? MEMORIAL HOSPITAL 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
Street No. 215 S. CENTRE ST., CITY (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Owen MR. LAWRENCE A WADE

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MABEL VAN HORN
6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) JULY 22 1890

8. AGE: Years	Months	Days	If less than one day
50	3	23	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation UNEMPLOYED 5 YEARS
11. Industry or business

FATHER
12. Name HERSEY WADE
13. Birthplace MARYLAND

MOTHER
14. Maiden name DORA RICE
15. Birthplace MARYLAND

16. Informant Mrs Mabel Wade
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 18 40 (month) (day) (year)
Cemetery or crematory Greenmont Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland

19. Nov 18 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 15 1940 at 7:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1940 to Nov 15 1940 and that I last saw h.. alive on Nov 15 1940

Immediate cause of death	DURATION
Perforated gastric ulcer	1 day
Due to	
Due to	
Other conditions Lobar pneumonia	3 days

(Include pregnancy within 3 months of death)

Major findings of operations perforated gastric ulcer
Date of op. 11-10-40
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. M. Wilson, M.D. M. D. or other
Address Cumberland Md Date signed 11-16-40

DR. DURRETT & WILSON

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 1 — 11296

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Fort Ashby
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: JOHN WALKER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married (Separated)

6.(b) Name of husband or wife: Margaret Greenwald

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): AUG. 11, 1870

8. AGE: Years	Months	Days	If less than one day
70	3	17	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Fires engine on Saw-Mill

11. Industry or business

FATHER — 12. Name: Edward Walker

13. Birthplace —

MOTHER — 14. Maiden name: Mary Heavner

15. Birthplace —

16. Informant: K.H.RATCLIFF

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1-1940 (month) (day) (year)

Cemetery or crematory: Fort ashby

Location: Fort ashby W.Va.

18. Funeral director: Gutheim Funeral Home

Address: Cumberland Md

19. Nov 30 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28, 1940 at 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1940, to Nov 28 1940 and that I last saw h.... alive on Nov 28, 1940

Immediate cause of death	DURATION
Fractured skull	2 wks
Due to: Automobile	
Due to: accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Nov 14, 1940

Where did injury occur? Mineral Co. W.Va.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on road

Means of injury struck by automobile Injured at work? yes

23. SIGNATURE: J. M. Wilson M.D.
M. D. or other

Address: Cumberland Md Date signed 11-29-40

Dr. Wilson

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Peter L. Ward 11297

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

~~Hospital, Institution~~, or street address where death occurred: 408 Beall St

How ~~long~~ in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Beall St. (If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Peter Louis Ward

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband ~~or wife~~: Cecelia Kean

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): April 25, 1883

8. AGE: Years	Months	Days	If less than one day
57	6	8	...hrs. ...min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Wire Chief. W.U. Telegraph

FATHER 12. Name: Louis Ward

FATHER 13. Birthplace: Penna

MOTHER 14. Maiden name: Bridget Riley

MOTHER 15. Birthplace: Penna

16. Informant: Mrs Cecelia Ward

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6-40 (month) (day) (year)

Cemetery or ~~cemetery~~: St Patricks Cem

Location: Cumberland Md

18. Funeral director: V. L. Lamberson

Address: Cumberland, Md.

19. Nov 5 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3, 1940, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1936 to Nov. 3, 1940.

and that I last saw him alive on Nov. 2, 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 years
Due to	
Due to	
Other conditions: Pulmonary edema	2 days

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. C. Zimmerman M.D. (M. D. or other)

Address: 105 S. Centre St. Cumberland, Md. Date signed 11-4-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11298

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1D.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Weddle

3. (b) Social Security Number: Infant

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1940

8. AGE: Years | Months | Days: 1E | If less than one day: 22 hrs. 35 min.

9. Birthplace: Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Mr. Joseph Weddle
13. Birthplace: Cumberland, Maryland

MOTHER
14. Maiden name: Mrs. Mary Shipway ~~Weddle~~
15. Birthplace: Accident, Maryland

16. Informant: Mr. Joseph Weddle
Address: Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1940 (month) (day) (year)
Cemetery or crematory: Robinette Cem
Location: Flintstone, Md

18. Funeral director: J.C. Wolford
Address: Cumberland, Md.

19. Nov. 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1940, at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25 1940, to Nov. 25 1940, and that I last saw him alive on Nov. 25 1940.

Immediate cause of death	DURATION
Prematurity (30 wks gestation)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other
Address: 402 N. Liberty St. Date signed 11-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1940
BUREAU V. S.

(M) WITHIN CORPORATE LIMITS.

(S)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

11299

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 716 Gephart Drive
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Welsh

3. (b) Social Security Number

4. Sex: ?

5. Color or race: W

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife .....

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland, Md. Allegany Co.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business

FATHER
12. Name: Robert William Welsh
13. Birthplace: Washburn Wis.

MOTHER
14. Maiden name: Anna Mary Farrell
15. Birthplace: Elkins, W. Va.

16. Informant .....

Address

17. Cremation
(Burial, cremation, or removal. Which?)

Date thereof: Nov 30 1940
(month) (day) (year)

Cemetery or crematory: Home Furnace

Location: 716 Gephart Dr.

18. Funeral director: Self

Address

19. 12-3 1940 J. P. Franklin MD
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30 1940 5:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ....., to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death: Miscarriage — DURATION: 3 Mo.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. N. Trevaskis MD, M. D. or other

Address: Cumberland, Md Date signed: Dec 2-40

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

11300

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

14 N. Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 N. Lee St.

(If rural, give LOCATION)

2.(o) If veteran, name war

3. (a) FULL NAME Jacob Wm. Whitacre

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Emily A. Beaton

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): March 22, 1862

8. AGE: Years	Months	Days	If less than one day
78	7	16	hrs. min.

9. Birthplace: Okonolee, Hampshire Co., W. Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER 12. Name: Wm. Whitacre

FATHER 13. Birthplace: Hampshire Co., W. Va.

MOTHER 14. Maiden name: Mary Silvaugh

MOTHER 15. Birthplace: Don't know

16. Informant: Sarah E. Oliver

Address: 14 N. Lee St, Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11 1940 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Mt. Savage Md.

18. Funeral director: Jacob J. Hofer

Address: Cumberland Md.

19. Nov. 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6, 1940, to Nov. 8, 1940, and that I last saw h. alive on Nov. 7, 1940

Immediate cause of death: Adenoma - Stokes disease — DURATION: 2 days.

Due to:

Due to:

Other conditions: Epilepsy

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel A. Jackson M.D. M. D. or other

Address: 119 Bedford St. Date signed 11/11/40

RECEIVED
DEC 6 1940
BUREAU T. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

11301

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 16 Altamont Terrace (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Ann Rundel Wickard

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: James B. Wickard

6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Oct 18, 1860

8. AGE: Years: 80 Months: 1 Days: 2 If less than one day: ..... hrs. ..... min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: ? Was an Orphan
13. Birthplace: Parentage Unknown

MOTHER
14. Maiden name: ?
15. Birthplace:

16. Informant: James B. Wickard

Address: 16 Altamont Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 23 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: Jacob Hofer

Address: 230 Baltimore Ave.

19. Nov 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

J. P. Snyder.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20 1940 at 2 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 25, 1940, to Nov. 20, 1940 and that I last saw her alive on Nov. 20 1940

Immediate cause of death: Bronchial Pneumonia

Due to: Pract. Mech. Sept. Trans. 2 Mo

Due to: Due to an accidental fall, in the bathroom of her own home. C.W.G.R.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: Accident Date of: 9-25-40

Where did injury occur? Own Home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: C. V. O. Snyder M.D. or other

Address: Cumberland, Md. Date signed: 11-22-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

11302

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 1 wk

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 Shriner Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha J Zapf

3.(b) Social Security Number 217-10-7370

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 22 1918

8. AGE: Years	Months	Days	If less than one day
22	8	29	hrs. ..... min.

9. Birthplace Cumberland
(Town, county, and state)
10. Usual occupation Silk worker
11. Industry or business Celanese Corp
FATHER 12. Name Geo E. Zapf
13. Birthplace Cumberland Md
MOTHER 14. Maiden name Agnes R Hodel
15. Birthplace Cumberland Md
16. Informant Leo Zapf
Address 807 Shriner Ave
17. Burial, cremation, or removal (Which?) Date thereof 11-23-40
(month) (day) (year)
Cemetery or crematory St Patricks Cemetery
Location Cumberland Md
18. Funeral director Virgil L Lemperes
Address 707 Greene St Cumberland
19. Nov 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1940 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1940 to Nov 19 1940 and that I last saw h[illegible] alive on Nov 19 1940

Immediate cause of death	DURATION
Acute Nephritis	4 weeks
Due to	
Due to	
Other conditions Uremia	20 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. M. Trevaskis M.D.
M. D. or other
Address Cumberland Md Date signed Nov 22 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.